LIC # 0D80851
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Workers' Compensation

How did you hear about us?

❒ BIA ❒ Chamber of Commerce ❒ Current Client ❒ Email
❒ Google ❒ Mailer ❒ Yahoo ❒ Yellow pages
❒ Referral: _____ ❒ Website: _____

Named insured _____ Contractor's License #_____

Owner's name _____ Contact's name _____

Phone #: _____ Cell # _____ Fax # _____

Email: _____ Preferred method of contact: ❒ Phone ❒ Fax ❒ Email ❒ Mail

Mailing address: _____

Physical/Premise address _____

Business entity: ❒ Sole proprietorship ❒ Partnership ❒ Corporation ❒ LLC ❒ Other: _____

Business License # _____ FEIN: _____ SSN: _____

Hours of operation: _____ Out of state travel? ❒ Yes ❒ No

Number of years in business _____ Number of years experience _____

Do you require any special filings (ie MCP, etc)? If so, please provide details: _____

Ownership Information:

Full Name	Include or Exclude?	Date of birth	Percentage of ownership	Official title	Active in the field?
	❒ Inc ❒ Exc				❒ Yes ❒ No
	❒ Inc ❒ Exc				❒ Yes ❒ No
	❒ Inc ❒ Exc				❒ Yes ❒ No
	❒ Inc ❒ Exc				❒ Yes ❒ No

Describe, in detail, the operations performed by you and your employees:

_____

_____

_____

THIS IS NOT AN APPLICATION, IT IS ONLY A PRELIMINARY INFO SHEET FOR A QUOTE.
ADDITIONAL INFORMATION MAY BE REQUIRED.

Maximum height in feet: _____ Type of work: _____

❒ Scaffolding (your own) ❒ Scaffolding (leased/rented) ❒ Ladder ❒ Scissor Lift

Maximum depth in feet: _____ Type of work: _____

Do you use subcontractors? ❒ Yes ❒ No % of work subcontracted? _____

Average annual gross receipts? _____

The following is the basis of the quote, and must be provided:

Class Code or Description (please be as complete as possible)	Expected Annual Payroll	Average Hourly Wage	Number of employees Full Time	Part Time

Have you had prior coverage during the last five years? ❒ Yes ❒ No **Loss run reports will be required.**

Have there been any losses or claims in the last five years? ❒ Yes ❒ No

Is your coverage currently in force? ❒ Yes ❒ No Expiration date: _____

Carrier: _____

Do you offer any of the following benefits?

❒ Group Health (Would you like a quote? ❒ Yes ❒ No) ❒ Paid Sick Leave

❒ Paid Vacation ❒ Retirement Plan/Pension Plan ❒ Other: _____

Do you use a specific clinic, physician, or emergency room? _____

Do you use any of the following hiring practices?

❒ Employment applications ❒ Reference checks ❒ Motor vehicle reports

❒ Volunteer labor ❒ Temporary labor ❒ Drug/substance abuse testing

❒ Pre/post employment physical ❒ Back testing ❒ Other: _____

Do you use any of the following safety programs or precautions:

❒ Injury & Illness Prevention Plan ❒ Safety Incentive Plan ❒ Employee Orientation

❒ Formal Written Accident Report ❒ Safety training/meetings ❒ Personal Protection Equipment

❒ Post accident drug testing ❒ Other _____

_____ _____

Signature of Prospective Insured Date

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