

Workers Compensation Quote Request

Requested Coverage Effective Date: _____

Business Information:

Applicant's Legal Name: _____

DBA: _____

Mailing Address: _____

Number of Years in Business: _____

_____ Individual _____ Corporation _____ Subchapter "S" Corp _____ Partnership
_____ LLC _____ Other(please explain)

FEIN#: _____

NCCI Risk ID #: _____

Location Adresse(s):

Contact Name: _____

Business Phone #: _____

Website Address: _____

Fax #: _____

Cell Phone #: _____

Email Address: _____

Complete Description of Work/Operations: (you may attach brochures or any other literature)

******* Please attach to this quote request: 3 to 5 years currently valued claims history, a copy of your most recent or current policy, and your NCCI e-mod worksheet *******

Complete List of all Owners & Officers of the Business:

*Name: _____ Title: _____

D.O.B _____ Ownership % _____

Estimated Annual Payroll: _____ Include or Exclude from Coverage? _____

Job Description: _____

*Name: _____ Title: _____

D.O.B _____ Ownership % _____

Estimated Annual Payroll: _____ Include or Exclude from Coverage? _____

Job Description: _____

Number of years experience in this industry: _____

*Name: _____ Title: _____

D.O.B _____ Ownership % _____

Estimated Annual Payroll: _____ Include or Exclude from Coverage? _____

Job Description: _____

Number of years experience in this industry: _____

Policy Rating Information:

Department Name: _____

Job Description: _____

Part Time: _____ Estimated Annual Payroll:

Full Time: _____ \$ _____

Department Name: _____

Job Description: _____

Part Time: _____ Estimated Annual Payroll:

Full Time: _____ \$ _____

Department Name: _____

Job Description: _____

Part Time: _____ Estimated Annual Payroll:

Full Time: _____ \$ _____