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ALASKACOMMERCIAL
INSURANCE BROKERS

Workers Compensation Application

Business Information

Business Name: _____ Phone: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip: _____

Year Established: _____ Structure: _____ FEIN Number: _____

Email: _____ Website: _____

Description of Operations: _____

Principal Information

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ DOB: _____ SSN: _____

Email: _____

Insurance Information

Proposed Effective Date: _____ Previous Carrier: _____

Policy Number: _____ Any Prior Lapse of Coverage: Yes No

Prior Losses if Any	Date	Amount of Loss

Employee Information

Number of Employees: FT _____ PT: _____ Forecast Annual Payroll: _____

Job Title	Description/Class Code	Payroll
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Please attach an experience modification worksheet if able.

Ownership Breakdown

Name	Ownership Percentage	Wages
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Additional Requests or Comments

Signature: _____

Date _____