WORKERS' COMPENSATION QUOTE FACT SHEET

Company Name:________________________ Trade Name (i.e. DBA): _______________________________

Business Ownership—Legal Name: ____

Phone #___________________ Fax # ____________________ Number of Locations: __________________

Email _________________________________ Website: ____

Company Address:____

City: ______________________________________ State: _____________ Zip code: __________________

Mailing/Billing Address:____

City: _______________________________________ State: _____________ Zipcode: __________________

Contact Name & Title: ____________________________Federal Employer ID #: _______________________

State Employer ID #:________________ Years in Business: ______ Date Business Began: ___/___/_______

Legal Entity: Individual____ Husband & Wife _____ Partnership _____ Corporation ________ 'S' Corp _____

Limited Corp___Other____

Group Health Carrier: ____

Current W/C Carrier: ________________Expiration Date: ___/____/___ Requested Effective Date:__/__/____

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Rating Information (**Refer to your current policy**):

Class Code	Job Description	# Full-time Employees	# Part-time Employees	Estimated Payroll	Rate	Estimated Annual Premium

List partners, officers, or relatives. (If officers are listed—please provide names of all officers as listed on your corporate papers—Pres, VP, Secr, and Treasurer.)

Name	Date of Birth	Title	% of ownership	Duties	Estimated Annual Premium

Prior Carrier Information and Loss History: (Please provide information for the past 4 years.)

Year	Carrier	Policy #	# of Claims	Amount Paid

Nature of Business / Description of operations (Be specific):____

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Completed by ______________________________, Title_________________________ Date: _________