Workers' Compensation Quote Questionnaire

TEL/FAX : 1866-491-7853

Agent Name: ______ Phone: ______

Effective Date for Quote: ______

Business Name: ______

Premises Address: ______

City: ______ State: ______ Zip Code: ______

Contact Name: ______ Phone: ______

Federal Employer's ID#: ______

Type of Business: ☐ Individual ☐ Partnership ☐ Corporation ☐ LLC ☐ Subchapter S Corp. ☐ Nonprofit

☐ Other: ______

Detailed Description of Day-to-Day Operations

Year this business started under the current ownership: ______

Years of total overall experience the owner has in this business type: ______

Losses past 3 years: ☐ Yes ☐ No

Description of losses or if possible, please include currently valued loss runs:

# of full-time employees: ______ # of part-time employees: ______ # of locations: ______

Estimated Total Annual Payroll: $ ______ Experience Mod (if any, per policy): ______

Do you require increased limits beyond 100/500/100? If so, please state limits needed: ______

Employee Information:

Employee Type	Job Description	Class Code	Annual Payroll Estimate
1			
2			
3			
4			
5			

Officers / Partners / Owners Information:

Principal	Name	Title	Class Code	Exclude from Coverage? Yes or No
1				
2				
3				