WORKERS' COMPENSATION APPLICATION

DATE:______________________________PRODUCER:_________________CLIENT#:____________________

INSURED NAME:____CONTACT:________________________

ADDRESS:_________________________________CITY:________________ST:___________ZIP:___________

PAYROLL INFORMATION

CLASS CODE	PAYROLL	# FT EMPLOYEES	# PT EMPLOYEES
8832 - Dentist			
8810 - Clerical			
7380 - Drivers			
8742 - Sales			

FEDERAL ID#: _____________________________TAX ID#:____
AK,CO,FL,IN,ME,MN,NM,NJ,NY

EXPERIENCE MOD:___________BUREAU ID:_________________

EMPLOYER LIABILITY LIMITS:
☐$100,000/$500,000/$100.000
☐$500,000/$500,000/$500,000
☐$1,000,000/$1,000,000/$1,000,000
☐$2,000,000/$2,000,000/$2,000,000 - CA

COVERAGE INCLUSIONS/EXCLUSIONS

NAME	TITLE	INCLUDE/EXCLUDE
		☐INCLUDE ☐EXCLUDE
		☐INCLUDE ☐EXCLUDE
		☐INCLUDE ☐EXCLUDE

RISK MANAGEMENT

Number of Years in Business:____________
Incidents are reported upon occurrence directly to the insurance company - ☐Yes ☐No
Records are kept of all incident reports - ☐Yes ☐No
Are employees hired - ☐Previously Trained ☐Trained Upon Hire
Is appropriate safety equipment used - ☐Yes ☐No
Number of Management Personnel:_______________Number of Employees:_________________________
Employees attend regular training seminars - ☐Yes ☐No

LOSS HISTORY

DATE OF LOSS	DESCRIPTION	MED/IND	AMOUNT PAID

CURRENT INSURANCE COMPANY:_________________________ANNUAL PREMIUM:_________________