

WORKERS' COMPENSATION APPLICATION

DATE: _____

INSURED NAME: _____ CONTACT: _____

ADDRESS: _____ CITY: _____ ST: _____ ZIP: _____

PAYROLL INFORMATION

CLASS CODE	PAYROLL	# FT EMPLOYEES	# PT EMPLOYEES
8832 - Denturist			
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
		<input type="checkbox"/> INCLUDE <input type="checkbox"/> EXCLUDE
		<input type="checkbox"/> INCLUDE <input type="checkbox"/> EXCLUDE
		<input type="checkbox"/> INCLUDE <input type="checkbox"/> 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: _____