Workers Compensation Questionnaire

Business Name:		
Mailing Address:		
City:	St:	Zip:

Phone Number:	Fax Number:
Contact Name:	Email:

Business Type:	☐ Corporation	☐ Partnership	☐ LLC
	☐ Trust	☐ Individual	☐ Other

FEIN:	
Number of Years in Business:	Effective Date:

Current Carrier (if any):

Any Losses in the last 3 years? ☐ Yes ☐ No
If Yes, How many?

Description of Operation:

Physical address for each property:

1.
2.
3.
4.
5.

Employees:

Description	Full / Part Time	Payroll/Rent Credit
1.		
2.		
3.		
4.		
TOTAL		

Exclude (Name)	Title	% of Ownership
1.		
2.		
3.		
4.		

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