COADY INSURANCE AGENCY
562.400.6839

# Workers Compensation Questionnaire

| | | | |
|---|---|---|---|
| Business Name: | | | |
| Mailing Address: | | | |
| City: | St: | | Zip: |
| Phone Number: | | Fax Number: | |
| Contact Name: | | Email: | |
| Business Type: | ☐ Corporation ☐ Trust | ☐ Partnership ☐ Individual | ☐ LLC ☐ Other |
| FEIN: | | Number of Years in Business: | |
| Current Carrier (if any): | | Effective Date: | |
| AAGLA Member #: | | | |
| Any Losses in the last 3 years? ☐ Yes ☐ No<br>If Yes, How many? | | | |
| Description of Operation: | | | |

| Physical Address for each Property: | # of Units: |
|---|---|
| 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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