Workers' Compensation Quote Questionnaire

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: Select One Y ☐ N ☐

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:
_____

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Employee Information:

Employee type	Job Description	Annual Payroll Estimate
1	_____	_____
2	_____	_____
3	_____	_____
4	_____	_____
5	_____	_____

Officers / Partners / Owners Information:

Principal	Name	Title	Exclude from coverage?
1	_____	_____	Y ☐ N ☐
2	_____	_____	Y ☐ N ☐
3	_____	_____	Y ☐ N ☐