

WORKER'S COMPENSATION INSURANCE QUOTE SHEET

Business Name _____

Contact Person _____

Address _____

Phone: _____ Fax _____ email: _____

Job Classification <input type="checkbox"/> <input type="checkbox"/>	Code <input type="checkbox"/> <input type="checkbox"/>	Annual payroll per class
_____ <input type="checkbox"/>	_____ <input type="checkbox"/> <input type="checkbox"/>	_____
_____ <input type="checkbox"/>	_____ <input type="checkbox"/> <input type="checkbox"/>	_____
_____ <input type="checkbox"/>	_____ <input type="checkbox"/> <input type="checkbox"/>	_____
_____ <input type="checkbox"/>	_____ <input type="checkbox"/> <input type="checkbox"/>	_____

General Description of Business Operations:

What date was this company started? _____

Policy renewal date? _____

Amount & Number of Claims in last five years: _____
Number Amount

Prior Worker's Compensation Insurance Carrier: _____

Experience Modification % : _____

Name/Title of Executive Officers <input type="checkbox"/> <input type="checkbox"/>	Duties <input type="checkbox"/> <input type="checkbox"/>	Salary <input type="checkbox"/>	Include or Exclude?
_____ <input type="checkbox"/> <input type="checkbox"/>	_____ <input type="checkbox"/>	_____ <input type="checkbox"/>	_____
_____ <input type="checkbox"/> <input type="checkbox"/>	_____ <input type="checkbox"/>	_____ <input type="checkbox"/>	_____
_____ <input type="checkbox"/> <input type="checkbox"/>	_____ <input type="checkbox"/>	_____ <input type="checkbox"/>	_____