

## Worker's Compensation Questionnaire

Insured Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Insured Address: \_\_\_\_\_

FEIN #: \_\_\_\_\_

Individual \_\_\_ Partnership \_\_\_ Corporation \_\_\_ Limited Corp \_\_\_ Other \_\_\_

Phone No. : \_\_\_\_\_ Inspection Contact Person: \_\_\_\_\_

Business Description: \_\_\_\_\_

Years in Business: \_\_\_\_\_

Policy Period: \_\_\_\_\_

Prior Carrier Information (4 years loss run required, if any): \_\_\_\_\_

Loss Details, if any: \_\_\_\_\_

State	Loc.	Code	Description	# Employee		Est. P/R
				F / T	P / T	

Owner Name	Title	Ownership %	Inc / Exc

Health Insurance Provider \_\_\_\_\_ Employer pays \_\_\_\_\_ % of premium

Business Hour \_\_\_\_\_ Sick Leave \_\_\_\_\_ Vacation \_\_\_\_\_ 401K \_\_\_\_\_

Out of State Travel Exposure: # of Employee \_\_\_\_\_ How Often \_\_\_\_\_

Lifting Exposure: \_\_\_\_\_ Lbs Maximum

Delivery Frequency \_\_\_\_\_ Radius \_\_\_\_\_ miles