

**WORKERS' COMPENSATION QUESTIONNAIRE**

Corporate Name \_\_\_\_\_

DBA \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone ( ) \_\_\_\_\_ Fax ( ) \_\_\_\_\_

e-mail \_\_\_\_\_

Insurance Carrier (or None) \_\_\_\_\_

Insurance Contact Person \_\_\_\_\_

Policy # \_\_\_\_\_

Expiration Date \_\_\_\_\_

Annual Premium \_\_\_\_\_

Payroll – Sales \_\_\_\_\_

Payroll – Clerical \_\_\_\_\_

Number of Licensed Agents \_\_\_\_\_ Number of Clerical \_\_\_\_\_

Federal Employer ID# \_\_\_\_\_

**Partners and Officers**

<b>Name</b>	<b>Title</b>	<b>Ownership And Duties</b>	<b>Exclude/ Include</b>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(Please fax back to 1-888-567-1522)