Workers Comp Quote Information

Company Name(DBA): ____________________________________
Contact: ____
Address: ____
____
City: ______________________________ State: ______ Zip: _________

Fed Tax ID Number: ________________ Yrs in business: ______ # of employees:_____

Code: ___________ Type of work:______________________ Payroll $___________
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Officers/Owners:
Name ______________________ DOB: _______ Salary: ____________Ownership___%
Name ______________________ DOB: _______ Salary: ____________ Ownership___%
Include officers? ☐ Exclude officers? ☐

Have you subscribed to WC coverage during last two (2) years ☐ yes ☐ no

List WC coverage for last three years:
Year: ____ Co name: ___________________________ policy # __________________
Year: ____ Co name: ___________________________ policy # __________________
Year: ____ Co name: ___________________________ policy # __________________
Prior years premium: $ ___________ $___________ $___________

Current Experience Modifier: ______ ☐ None # of claims in any single year: ___ ☐ none

Largest incurred single loss: $ ______________ Does loss ratio exceed 60% ☐ yes ☐ no

Do you use subcontractors? ☐ yes ☐ no If yes, Subcontractor annual cost $_________________

Area (states) of operation: ________________ Gross Annual Sales: $____________

Do you need an out of state WC policy coverage? ☐ yes ☐ no

Email

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