

Workers Compensation

1) Employer Name: _____

Corporation Partnership Sole Proprietor Other _____

2) FEIN: _____

3) State ID #: _____

4) Location Address: _____

Mailing Address:
(If Different)

Phone: _____

Email: _____

5) Payroll Schedule:

Class Code	Duties	# Employees FT/PT	Est. Annual Payroll

6) Ownership Schedule:

Name	Title	% Ownership	Duties	Incl. or Excl.	Annual Payroll

7) Prior Carrier Information:

Year	Policy #	Carrier	Annual Premium	Exp. Mod.	# Claims	Paid	Reserve

8) Description of Operations: _____

9) Do you have a written Safety Plan?

Yes

No

10) Do you have an employee handbook?

Yes

No