

# Worker's Compensation / Employer's Liability Information Schedule

Please complete the following information and return fax to our office. Please call if you need any help or to schedule a meeting.

Company Name \_\_\_\_\_ Contact Name: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Physical Location if different than mailing: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ email: \_\_\_\_\_

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

Federal Tax ID Number: **(Required)** \_\_\_\_\_ Business Started: \_\_\_\_\_

Company Structure:  
 Corporation    Individual    Partnership    Subchapter "S" Corp.

Locations: Street, City, County, State, Zip Code

1.
2.
3.

**PLEASE COMPLETE KNOWN INFORMATION**

Proposed Eff. Date: \_\_\_\_\_ Current Exp. Mod.(Workers Comp.): \_\_\_\_\_

Current Carrier/Leasing Company: \_\_\_\_\_ Current Rate: \_\_\_\_\_

Do you provide Employee Benefits? Y N Carrier \_\_\_\_\_ Renewal Date: \_\_\_\_\_

Rating Information:

Categories, Duties, Classifications Of Employees	No. of Part Time Empl.	No. of Full Time Empl.	Estimated Annual Payroll

**Individuals Included/Excluded (Required)**

Name	Title	Ownership %	Included/E xclude	Remuneration

**Loss Information**
