Request for Quote Form
Workers Compensation Policy

Name of Business: ____

Check one: Corporation ____ LLC ____ Partnership ___

Individual / Sole Proprieter ____ Other ____

Address: ____

Mailing Address: ____

Contact Person: ____

Phone Numbers: ___________________ Fax Number: ______________________

E-Mail: ____

Website: ____

Description of Operations ____

List States in which the entity operates: ______________________________

Years in Operation: ____

Federal ID Number / SS#: ____

Do you currently have insurance: Yes ____ No _____

If yes : Current Company_______________________

Expiration Date of Policy: ________________

Have you had any losses? Yes ______ No _____

Do you have an Experience Modification Factor? ______

If yes: What is it? _________

Requested Employer's Liability Limit: $ _____________

Classification/Description:	Payroll	State	# of Employees - FT/PT

List all Partners, Officers, Owners:

Name	DOB	Title	% Owned	Duties	Incl/Excl	Remuneration

Any Leased Employees? Yes [ ] No [ ] Any Employees Work at Home? Yes [ ] No [ ]