WORKERS COMP QUOTE INFORMATION

DATE:_____

NAME:_____DBA_____PHONE:_____

LLC S CORP INCORP INDIVIDUAL YEARS IN BUSINESS:_____

TAX ID:_____

MAILING ADDRESS:_____CITY_____ZIP:_____

LOCATION ADDRESS:_____CITY_____ZIP:_____

COUNTY:_____

EMAIL:_____WEBSITE:_____

NAME OF CURRENT CARRIER:_____EXPIRATION DATE:_____

LOSSES IN THE LAST 5YEARS_____

_____

TYPE OF BUSINESS:_____

NUMBER OF EMPLOYEES:_____FULL TIME_____PART TIME_____

EMPLOYEE TITLE_____ANNUAL SALARY_____

EMPLOYEE TITLE_____ANNUAL SALARY_____

EMPLOYEE TITLE_____ANNUAL SALARY_____

EMPLOYEE TITLE_____ANNUAL SALARY_____

SEASONAL WORK Y/N

LIABILITY LIMITS_____

****ASK WHO HAS PERSONAL INSURANCE POLICIES-NEED A QUOTE FOR THAT ALSO**

INITIALS: _____