Jan 2014

WORKERS COMPENSATION WORKSHEET

Business Name(s)			Contact Name
Owner(s)			Business #
Mailing Address	Street		Cell #
	City	State Zip	Fax #
	County		Email

Individual _____ Partnershp _____ Corp _____ LLC _____ Joint Vent. _____ Other _____

Description of Business Operations:

84 Sales Rep	84 Store Location
Date Business Started:	Years Experience (In Trade):
FEIN or SSN:	States You Work In:

Current Work Comp Carrier (Not Agent) ____________________ # Years Insured _____

Experience Mod ____________ Policy Number ____________________

IMPORTANT: Please request Loss Runs for the current year plus the previous 3 years from your WC carrier(s)

Have you had any WC claims in the last 5 years? _____ (If yes, provide details in Comments section below)

OWNERS

NAME	TITLE	% Ownership	Included / Excluded

Number of Employees (Excluding Owners) --	Full Time:	Part Time:
PAYROLL & CLASSIFICATION		
Carpentry (Excluding Owners) --	Full Time $:	Part Time $:
Clerical (Excluding Owners) --	Full Time $:	Part Time $:
Other Classifications --	Full Time $:	Part Time $:
Other Classifications --	Full Time $:	Part Time $:
Owner Payroll -- $		

SUBCONTRACTORS

Are Subcontractors Used? _____ Percentage of Work Subcontracted: _____

Are Certificates of Insurance Obtained For All Subs? _____

If Any UNINSURED Subs:

Classification: ____________________ Labor Cost: $ ____________

Classification: ____________________ Labor Cost: $ ____________

Comments:

877-866-1384 x2108

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