Worker's Compensation

Business Name ___________________________________
Business Entity (i.e. Corp, LLC, Partnership) ________________________________
Mailing Address ____
Business Address if different ____
Phone _____________ Fax _________________ Email ________________________
Your name ____
Your position ____

Federal ID # _________________________
Number of full time employees_____________
Number of part time employees _____
Please classify your employees according to their duties: (i.e. how many clerical, how many warehouse, how many sales people, how many managers etc.)
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Total annual payroll for all employees including owners/officers ___________________
If you are incorporated, are the executive officers excluded from coverage? ___________
Amount of payroll for owners/executive officers only __________________
Annual gross receipts______________________
Do you have any employment benefit plans? (i.e. health insurance or retirement)__________________________
ERISA required? _______________________
Do you have a formal written safety protocol? _________________________

What is the best way to contact you?_________________________________
What is your current Worker's Comp expiration date ____________________