



Workers' Compensation Insurance Application

Contact Information	Business Name:		
	Address:		
	City:	State:	Zip Code:
	Phone Number:		Fax Number:
	Contact Name:		Email:
	Additional Locations:		
1. _____			
2. _____			
3. _____			

Business Information	Business Structure (Check only one box):		
	<input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> LLC <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> 5013C <input type="checkbox"/> Other _____		
	Federal Tax Identification Number:		
	Brief Business Description:		
	_____ _____ _____ _____ _____		
Number of years in business:			
Proposed Effective Date:		Experience Modifier:	

Employee Classifications	Employee Classifications:	Estimated Annual Payroll:	Number of Employees:
	1. _____		
	2. _____		
	3. _____		
	4. _____		
	5. _____		

Claims History	Current Carrier and Policy Number:
	Please provide currently valued loss history for prior 4 years: