

**WORKERS COMPENSATION
QUESTIONNAIRE**

NAME & ADDRESS: (location where coverage is sought)

County: _____

Do you have any other business locations? Yes No *If Yes, please attach separate list.

Contact person: _____

Phone: _____ **Fax:** _____

Email: _____

Website: _____

Effective Date Requested: _____

Total Annual Payroll for all owners, officers & partners: _____

Total Annual Payroll for all other employees: _____

Are the Partners/Officers to be included in the coverage? Yes No

If YES, please provide a list of the Partners/Officers, Titles, percentage of ownership, and breakdown of individual payroll/salary on separate sheet.

Total Number of Employees: _____

Number of Full Time Employees: _____

Number of Part Time Employees: _____

LEGAL ENTITY:

Individual

Partnership

Corporation

Other: _____

NAME: _____

SIGNATURE: _____

DATE : _____