Workers Compensation Coverage Review

This information will allow us to make sure we provide your business with the best coverage and pricing available. Please take a moment to answer the questions below so we may address your needs accordingly.

Name of Business Entity: _____

DBA:

Location #	Physical Address- Street, City, State, Zip Code

Mailing Address: _____ Email: _____

Telephone: _____ Fax: _____

Accounting Records Contact: _____ Title: _____

Claims Contact: _____ Title: _____

Do you use Quickbooks® payroll? ☐ Yes ☐ No

Location #	Class Code	Payroll Currently Used	# of Employees F/T (next term)	# of Employees P/T (next term)	Annual Payroll (estimated for next term)
Do you want the Officers or Directors included for coverage?					

☐ Include ☐ Exclude Name: _____ % of stock owned: _____

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☐ Include ☐ Exclude Name: _____ % of stock owned: _____

☐ Include ☐ Exclude Name: _____ % of stock owned: _____

IMPORTANT: If Officers and Directors are not Excluded, at final Audit their payroll will be included and the appropriate additional premium will be charged.

Benefits:

Do you provide group medical? ☐ Yes ☐ No Employer Contribution: $_____

What percentage of employees are covered by the plan? % _____

Name of Provider: _____ Waiting Period: ☐ 30 Days ☐ 60 Days ☐ 90 Days

Who is eligible? ☐ ALL employees ☐ Only full time ☐ Other _____

Do you provide disability? ☐ Yes ☐ No Employer Contribution: $_____

Paid Vacation? ☐ Yes ☐ No

Paid sick leave? ☐ Yes ☐ No 401K Profit Sharing? ☐ Yes ☐ No

Are you interested in Employee Benefit Liability to protect your firm against suits due to errors or omissions in the administration of these plans? ☐ Yes ☐ No

Safety:

Person responsible for safety: _____ Phone: _____

Written Safety Program (SB198)? ☐ Yes ☐ No

Operations:

Operation includes delivery? ☐ Yes ☐ No

Number of authorized drivers? _____ Number of vehicles? _____

Frequency of deliveries? ☐ Daily ☐ Weekly ☐ Other _____

Delivery radius: ☐ 1-50 miles ☐ 51-100 miles ☐ 101-250 miles ☐ 250 + miles

Participation in CHP Pull Program? ☐ Yes ☐ No Vehicle inspection/maintenance program? ☐ Yes ☐ No

Vehicle maintenance performed by employees? ☐ Yes ☐ No Employees take vehicles home? ☐ Yes ☐ No

Do you have Independent Contractors? ☐ Yes ☐ No

Any work sublet without Certificate of Insurance? ☐ Yes ☐ No *If yes, their payroll might be subject to billing by your carrier. Please contact your agent for clarification or questions.

Truth of Statements: THE UNDERSIGNED DECLARES THAT THE STATEMENS SET FORTH HERIN ARE TRUE. THE UNDERSIGNED AGREES THAT IF THE INFORMAITON SUPPLIED ON THIS APPLICATION CHANGESS BETWEEN THE DATE OF THIS APPLICATION AND THE EFFECTIVE DATE OF THE INSURANCE, THE UNDERSIGNED WILL IMMEDIATELY NOTIFY THE INSURANCE COMPNAY OF THE CHANGES AND THE INSURANCE COMPANY MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS AND/OR AUTHORIZATION OR AGREEMENT TO BIND INSURANCE.

Print name of applicant: _____ Title: _____

Signature: _____ Date: _____

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