

Company Information

Business Name: _____ Fed. ID#

d/b/a: _____ SUTA Rate:

Physical Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Owners Name: _____ Years in business: _____

Email: _____ Cell: _____

Type of business: Sole Prop. Corp. Non-Profit L.L.C P.C. L.L.P. Partnership

Description of Operations:

States operating in: _____

Hazard Group	Class Code	Rate	# Employees	Description of Duties	Annual Payroll

Gen. Liability Expiration Date:

Copy of GL Cert. Attached Yes / No

3 years loss runs must be included with all submissions in order to receive a quote

Year	Carrier	Policy	Premium	MOD	# of Claims	Paid Losses	O.S. Res.

I attest to the best of my knowledge that all information provided is correct. I attest that no outstanding premiums are due to any other PEO.

Print Name:

Signature:

Date:

Company: _____

Workers' Compensation Questionnaire

YES NO

1	Does applicant own, operate or lease aircraft/watercraft?		
2	Does any past, present or discontinued operations which involve exposure to chemicals, painting or hazardous materials?		
3	Any work performed under, on or above water?		
4	Any work which may be subject to Jones Act, USL&H or FELA		
5	Any work performed underground or higher than 15 feet above ground?		
6	Any operations including excavation, tunneling, roadboring, earthmoving or other underground work?		
7	Any operations exposure to radioactive/nuclear materials?		
8	Any fatalities in the past 5 years?		
9	Is applicant involved in any business other than that specified in the description of operations?		
10	Does employee turnover exceed 30% annually?		
11	Do employees travel out of state or out of the country? If so, scope of travel?		
12	Any group travel, ride share programs, or tool or vehicle allowances provided?		
13	Are physicals required after offers of employment are made?		
14	Does the radius of operations vehicles exceed 200 miles?		
15	Are MRV's checked on all drivers?		
16	Is a "managed care" provider utilized?		
17	Is a written safety program in place? (Attach copy) If a program is in place, what is the schedule of safety meetings?		
18	Has applicant been inspected by OSHA in the past 3 years?		
19	Was applicant cited for any violations? If so, explain.		
20	Was applicant fined? If so, how much?		
21	Is a drug testing program in effect? (Attach copy)		
22	Is an early return/light duty policy in place?		
23	Does applicant "full pay" during periods of disability or reduced work?		
24	Are subcontractors used?		
25	If yes, are all subcontractors and their employees insured for Workers' Comp?		
26	Does applicant keep copies of their Certificates of Insurance?		
27	Any prior coverage declined, canceled or non-renewed in the past 3 years?		
28	What percentage of employees are enrolled in a group health plan?		

Signature _____

Print Name _____

Date _____

Company:

On question 11, if you answered that your employees travel out of state or out of the country. Please use the space below to define the scope of their travels, and various locations they travel to.

On question 17, if you answered that you had in place a safety program. What is the schedule of your safety meetings, if any?

On question 19, if you answered that you have been cited for violations by the OSHA within the last three years. Please explain below the violations you were cited for.

On question 20, if you answered that you have been fined by the OSHA for violations within the last three years. Please state the total amount of all fines resulting from these violations: \$

On question 24, if you answered that subcontractors are used, please explain what work is subcontracted and what percentage of total work is subcontracted.

Workers' Compensation Loss History Affidavit

I, _____, do hereby certify and swear that
(name of owner or officer)

(company name : dba)

has incurred _____ injuries within the last 36 months. Please list the injuries and the costs incurred in the table below for the last 36 months.

Year	Employee	Cost	Injury	Status

Note: If there have been no injuries, write (None) in the table above.

Explanation if an individual claim amount exceeds \$15,000.00

Must be completed. NO PREVIOUS WORKERS' COMPENSATION COVERAGE- Check here

If you have had Workers' Comp Coverage through another company within the last 36 months list company(s) below and attach loss runs from that company(s).

Company Name: _____

Signed by: _____ Date: _____

Title/Position: _____

Note: This affidavit must be submitted with the New Client Profile Sheets when loss runs are not available.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information with the purpose of avoiding or reducing the amount of premiums for workers' compensation coverage or crucial information pertinent to the computation and application of an experience rating modification factor, is guilty of a felony of the third degree or as otherwise punishable by law.