

WORKERS' COMPENSATION QUESTIONNAIRE

COMPANY INFORMATION

Company Legal Name: _____ Federal Tax ID#: _____ Year Established: _____
 DBA: _____ SIC: _____ Multiple Locations: Yes / No
 Business Address: _____ City: _____ Zip: _____
 Business Phone: () _____ Business Fax: () _____
 Contact Person: _____ Title: _____
 Contact Phone: () _____ E-Mail: _____

Type of entity: (Check One) C Corp S Corp Limited Liability Company Partnership Sole Proprietorship

Type of Business (Please describe your business operation): _____

PARTNER/OFFICER INFORMATION

| Name of Partner / Officer | Title | % of Ownership | Exclude from Coverage |
|---------------------------|-------|----------------|-----------------------|
| | | | Yes / No |
| | | | Yes / No |

EMPLOYEE INFORMATION

Number of employees: Full Time: _____ Part Time: _____ Estimated Annual Payroll: _____

* Please specify how much payroll is attributed to each employee type / class code:

| | | | |
|-----------------------------------|-----------------------|--------------------------|---------------------------|
| Employee Type / Class Code: _____ | # of Employees: _____ | Annual Payroll: \$ _____ | Current Class Rate: _____ |
| Employee Type / Class Code: _____ | # of Employees: _____ | Annual Payroll: \$ _____ | Current Class Rate: _____ |
| Employee Type / Class Code: _____ | # of Employees: _____ | Annual Payroll: \$ _____ | Current Class Rate: _____ |

Is Medical Insurance Provided?: Yes / No Name of Carrier: _____

WORKERS' COMPENSATION COVERAGE HISTORY

| Policy Year | Insurance Carrier | Policy Number | Premium: | Renew Date: | Ex-Mod: |
|------------------------|-------------------|---------------|----------|-------------|---------|
| <i>Current Carrier</i> | _____ | _____ | _____ | _____ | _____ |
| 2007 - 2008 | _____ | _____ | _____ | _____ | _____ |
| 2006 - 2007 | _____ | _____ | _____ | _____ | _____ |
| 2005 - 2006 | _____ | _____ | _____ | _____ | _____ |

WORKERS' COMPENSATION QUESTIONNAIRE

OTHER INSURANCE COVERAGES

| | | | |
|--------------------------------|----------------|----------------------|---------------------|
| Building | Carrier: _____ | Policy Number: _____ | Renewal Date: _____ |
| Property | Carrier: _____ | Policy Number: _____ | Renewal Date: _____ |
| General Liability | Carrier: _____ | Policy Number: _____ | Renewal Date: _____ |
| Automotive | Carrier: _____ | Policy Number: _____ | Renewal Date: _____ |
| Umbrella | Carrier: _____ | Policy Number: _____ | Renewal Date: _____ |
| Employment Practices Liability | Carrier: _____ | Policy Number: _____ | Renewal Date: _____ |
| Errors & Omissions | Carrier: _____ | Policy Number: _____ | Renewal Date: _____ |
| Directors & Officers | Carrier: _____ | Policy Number: _____ | Renewal Date: _____ |
| Health Insurance | Carrier: _____ | Policy Number: _____ | Renewal Date: _____ |
| Dental Insurance | Carrier: _____ | Policy Number: _____ | Renewal Date: _____ |
| Other | Carrier: _____ | Policy Number: _____ | Renewal Date: _____ |