



Daniels-Head  
Insurance  
Agency

Phone: (800)950-0551

Fax: (888)839-6107

# WORKERS COMPENSATION INSURANCE QUESTIONNAIRE

NAME & ADDRESS OF APPLICANT:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Contact Person: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Email: \_\_\_\_\_

LEGAL ENTITY:  Sole Proprietor  Corporation  Partnership  LLC  Other: \_\_\_\_\_

Name of your current Workers Compensation Insurance Company: \_\_\_\_\_ or  N/A

Effective Date Requested: \_\_\_\_\_ Physical location: \_\_\_\_\_

Description of Business / Services provided: \_\_\_\_\_

# of years in Business: \_\_\_\_\_ # of Years Experience in this type of Business: \_\_\_\_\_

Employer ID # (FEIN): \_\_\_\_\_ Total Annual Revenue / Receipts: \_\_\_\_\_

Total Number of Employees: # Full Time: \_\_\_\_\_ # Part Time: \_\_\_\_\_

Total Estimated Annual Remuneration / Payroll for Above Employees: \$ \_\_\_\_\_

Are Subcontractors/Independent Contractors Used?  Yes  No Are they insured?  Yes  No

### OWNERS OR CORPORATE EXECUTIVE OFFICERS TO BE INCLUDED / EXCLUDED FROM COVERAGE:

| Name | Title / Relationship | Ownership % | Duties | * INCL / EXCL | Annual Remuneration / Payroll |
|------|----------------------|-------------|--------|---------------|-------------------------------|
|      |                      |             |        |               |                               |
|      |                      |             |        |               |                               |
|      |                      |             |        |               |                               |
|      |                      |             |        |               |                               |
|      |                      |             |        |               |                               |

### MEMBERS OF PARTNERSHIPS OR LLC's TO BE INCLUDED OR EXCLUDED FROM COVERAGE:

| Name | Title / Relationship | Ownership % | Salaried or Equity Partner? | * INCL / EXCL | Annual Remuneration / Payroll |
|------|----------------------|-------------|-----------------------------|---------------|-------------------------------|
|      |                      |             |                             |               |                               |
|      |                      |             |                             |               |                               |
|      |                      |             |                             |               |                               |
|      |                      |             |                             |               |                               |
|      |                      |             |                             |               |                               |

\* Please indicate INCL if individual is to be included in coverage or EXCL if they are to be excluded

Have you had any CLAIMS within the last three years?  Yes  No

[If "yes," please provide date, detailed description, and corresponding total amount of payments for each claim]

SIGNATURE: \_\_\_\_\_

Owner, Officer or Partner

\_\_\_\_\_

Date