WORKERS' COMPENSATION APPLICATION

Completed applications should be faxed to 800 915 3922

Name of Organization: ______________________________ Requested effective date: ____/____/____

Mailing Address: ____
(street) (county) (city) (state) (zip code)

Physical Addresses: *(Attach extra sheet, if necessary)*

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(street) (county) (city) (state) (zip code)

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Phone: ____________________ Fax: ______________________ FEIN No.: ______________

Email address: ______________________________ Web site address: ______________________

Administrator or CEO/Insurance Contact Person: ______________________________________

Years in Business: _____ Annual Revenue: __________ How did you hear about us? ______________

Nature of Business: ____

Employee Classification	Number of Employees	Estimated Annual Payroll
Clerical (Office)		
Outside Sales / Marketing		
Supervisory/Intake Only RN		
Home Health / Field RN		
Nursing – ALF		
Domestic Aides		
Hospital Staffing		
Physician Offices		

(Other Classifications? Please Attach Extra Sheet.)

Names of Partners/Officers to be Included or Excluded from Coverage:

	Name	Date of Birth	Title	Ownership %	Inc/Exc
1.					
2.					
3.					

Do You?

- ☐ Have employees who regularly travel out of the state (as part of their job)? ☐ Yes ☐ No
- ☐ Sponsor any athletic teams? ☐ Yes ☐ No
- ☐ Have any labor interchange with any other subsidiary or affiliated company? ☐ Yes ☐ No
- ☐ Have any leased employees or volunteers? ☐ Yes ☐ No
- ☐ Have any 1099 or independent contractor labor relationships (PT's / OT's / MSW's)? ☐ Yes ☐ No

Please attach:

- Three Years Loss History, If Applicable

______________________________ ______________________
Submitter's Name/Signature Date