Sabal INSURANCE GROUP

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)*

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

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

Phone: _____ Fax: _____ FEIN No.: _____

Email address: _____ Web site address: _____

Administrator or CEO/Insurance Contact Person: _____

Years in Business: _____ Annual Revenue: _____

Nature of Business: _____

Employee Classification	Number of Employees	Estimated Annual Payroll
Clerical		
Outside Sales / Marketing		
Enter Description:		
Enter Description:		
Enter Description:		
Enter Description:		
Enter Description:		
Enter Description:		

(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:

- Estimated Annual Revenues
- A List of Employees
- Three Years Loss History, If Applicable