(818) 999-3747 x25
(818) 999-5047 (fax)

WORKERS COMPENSATION Questionnaire

****Named Insured**

****Mailing Address:**

****Premise Address:**

****Yrs in business**

****Nature of operations:**

****Current Insurance Company**

****Federal ID#**

****Estimated Annual Payroll**

****# of Employees**

****What do employees do? (class codes & payroll for EACH class)**

****Do you offer health? How much does company pay?**
****What Health Insurance Company**

****Owners Names**

****Does Owner(s) want to be <u>Included</u> or <u>Excluded</u> in workers comp coverage?**

****Need breakdown of ownership (ie: President, VP, etc) & % of the Company they own**

****Paid sick leave?**
****Paid vacations?**
****Hours of operations**
****Any delivery**

****Do you use <u>Quickbooks</u> for Payroll?**