



Phone: 818-264-0300 Fax: 818-264-0699

Workers Compensation Worksheet

1) Contact Person: _____ Requested Effective Date: _____(mm/dd/yy)

2) Trade Name (DBA): _____

3) Legal Name: _____

4) Mailing Address: _____

City: _____ State: _____ Zip: _____

5) Location Address (if different): _____

City: _____ State: _____ Zip: _____

6) Phone: _____ Fax: _____ Cell: _____

7) E-Mail Address: _____

8) Legal Entinty: Sole Proprietorship (Individual) Partnership Corporation " S" Corp LLC

9) Business Description: _____

Years in Business: _____ Radius Traveled from Office: _____ # miles

Federal ID #: _____ State Employer ID #: _____

10) Estimated Annual Payroll: \$ _____

11) BreakDown of Payroll by Class Code:

Job Description or Class Code	# Full Time	# Part Time	Payroll Amount
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

12) Owners/Officers:

Name	Title	% of Ownership	Date of Birth (mm/dd/yy)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Total (Must Equal 100%): _____

13) Are any Independent Contractors or Subcontractors used: Y ___ N ___ If yes, What pct _____%

14) Do you offer Health Insurance: Y ___ N ___ Pay at least 50%: Y ___ N ___ Provider: _____

15) Have you had any Workers Comp Claims in the last 3 years: Y ___ N ___ Amount?: \$ _____

16) Current Insurance Carrier: _____

17) Policy: # _____ **Expiration Date:** _____ (mm/dd/yy) **Premium: \$** _____

Signature: _____

Print Name: _____

Date: _____