WORKERS COMP INSURANCE QUOTE

REGISTERED CORPORATE NAME:____

ADDRESS: ____

PHONE #: ______________ **FAX #:** ________________**EMAIL:** ______________________________

CONTACT PERSON:_______________________ **# OF YEARS IN BUSINESS:** _______________________
NATURE OF BUSINESS:____ **TAX ID #:**________________

OWNERS	SS#	DATE OF BIRTH	% OF OWNERSHIP

ANNUAL SALES: $**_____________________ **ANNUAL PAYROLL:$_____________________

Employee Name	FT or PT	DOB	Social Security#	Title	Pay rate ($ salary per week or hourly)

ANY LOSSES IN THE PAST 3 YEARS:____
Letter on company letterhead stating no losses if none obtained ______ Past 3 years loss runs ordered _____

CURRENT W/C COMPANY:_________________ **CURRENT HEALTH COVERAGE?:**_________________

CURRENT ACCIDENT (AFLAC) COVERAGE?:____

CURRENT COMMERCIAL LIABILITY COVERAGE?:______________________________________

CURRENT AUTO COVERAGE?:____

FORMS NEEDED: -Owner Resume -UCT6/Payroll Report -Current Policy Loss Runs

ADDITIONAL INFORMATION:
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IMS/Connect return via fax to: 888-361-2634