Workers' Compensation Policy Quoting Worksheet

SECTION I

Requested Effective Date: _____ / _____ / _____

Primary Business Name: _____

Contact Name: _____

Mailing Street Address: _____ PO Box: _____

City: _____ State: _____ Zip: _____

Phone Number: (_____) _____ Email: _____

Federal Employer ID Number (FEIN): _____ Risk ID _____

Legal Entity: ◯ Individual ◯ Partnership ◯ Corporation ◯ Limited Liability Company ◯ Limited Liability Corporation

◯ Other Describe: _____

Years in Business: _____ If less than 3 years in business, number of years of management experience: _____

Describe your business: _____

_____

_____

SECTION II

Explain all "Yes" responses

1. Does the applicant own, operate, or lease aircraft/watercraft? ◯ Yes ◯ No

2. Do/have past, present, or discontinued operations involve(d) storing, treating, discharging, applying, disposing, or transporting of hazardous material?
(e.g. landfills, wastes, fuel tanks, etc) ◯ Yes ◯ No

3. Is any work performed underground or above 15 feet? ◯ Yes ◯ No

4. Is any work performed on barges, vessels, docks, or bridge over water? ◯ Yes ◯ No

5. Is applicant engaged in any other type of business? ◯ Yes ◯ No

6. Are sub-contractors used? (If "Yes," give % of work subcontracted) ◯ Yes ◯ No

7. Is any work sublet without certificates of insurance? (If "Yes," payroll for this work must be included in the State Rating Worksheet on Page 2) ◯ Yes ◯ No

8. Is a written safety program in operation? ◯ Yes ◯ No

9. Is any group transportation provided? ◯ Yes ◯ No

10. Does the applicant employ any employees under 16 or over 60 years of age? ◯ Yes ◯ No

11. Does the applicant employ any seasonal employees? ◯ Yes ◯ No

12. Is there any volunteer or donated labor? (If "Yes," please specify) ◯ Yes ◯ No

13. Any employees with physical handicaps? ◯ Yes ◯ No

14. Do employees travel out of state? (If "Yes," indicate state(s) of travel and frequency) ◯ Yes ◯ No

15. Are athletic teams sponsored? ◯ Yes ◯ No

16. Are physicals required after offers of employment are made? ◯ Yes ◯ No

17. Does the applicant have any other insurance with this insurer? ◯ Yes ◯ No

18. Has the applicant had any prior coverage declined/cancelled/non-renewed in the last three years? ◯ Yes ◯ No
(Missouri Applicants - Do not answer this question)

19. Are employee health plans provided? ◯ Yes ◯ No

20. Do any employees perform work for other businesses or subsidiaries? ◯ Yes ◯ No

21. Does the applicant lease employees to or from other employers? ◯ Yes ◯ No

22. Do any employees predominantly work at home? (If "Yes," indicate # of employees) ◯ Yes ◯ No

23. Has the applicant had any tax liens or filed for bankruptcy within the last five years? (If "Yes," please specify) ◯ Yes ◯ No

24. Are there any undisputed and unpaid workers' compensation premiums due from the applicant or any commonly managed or owned enterprises?
If "Yes," explain including entity name(s) and policy number(s). ◯ Yes ◯ No

25. Do you utilize a Return to Work program? ◯ Yes ◯ No

Please explain all "Yes" answers: _____

_____

_____

_____

SECTION III

1. Limits of Liability

Select one option: ◯ Option 1 ◯ Option 2 ◯ Option 3

Each Accident	100,000	500,000	1,000,000
Disease – Policy Limit	500,000	500,000	1,000,000
Disease – Each Employee	100,000	500,000	1,000,000

2. Locations

Location #1 Address: _____

City: _____ State: _____ Zip: _____

Complete the following chart with details about your staff (please separate the employees by class code):

Category of Employment	Class Code	# of Full-Time	# of Part-Time	Estimated Annual Income
				$
				$
				$

Location #2 Address: _____

City: _____ State: _____ Zip: _____

Complete the following chart with details about your staff (please separate the employees by class code):

Category of Employment	Class Code	# of Full-Time	# of Part-Time	Estimated Annual Income
				$
				$
				$

Please list any directors/officers to be excluded or included from this coverage:

Name	DOB	Title	Duties	Work Class Code	Income	Included/Excluded?
	/ /				$	
	/ /				$	
	/ /				$	

Section IV

1. Prior Insurance History:

Policy Year	Carrier & Policy Number	Annual Premium	# of Claims
		$	
		$	
		$	

2. Claim History:

Date of Claim	Description of Occurrence or Claim	Amount Paid	Amount Reserved	Status of Claim
/ /		$	$	
/ /		$	$	
/ /		$	$	

If claims have occurred, please provide at least three years of carrier loss runs.

Signature: _____ Date: _____ / _____ / _____

Title: _____