

# 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: _____

