



WORKERS' COMPENSATION QUESTIONNAIRE

1. Effective Date: _____ Fed Employer ID #: _____
2. Applicant's Name: _____
 DBA: _____
 Sole Proprietor Partnership Corporation LLC Other _____
3. Contact Name: _____ Email: _____
 Phone: _____ Fax: _____
4. Mailing Address: _____
5. Location Address: _____

6. Name of Owners - If Corp, provide % of ownership (must add up to 100%), duties, title, Exclude/Include:

7. Description	Class Code	Estimated Annual Payroll	Number of Employees	
			FT	PT
Retail Sales	(8008)	_____	_____	_____
Clerical	(8810)	_____	_____	_____
Outside Sales	(8742)	_____	_____	_____
Shoe Repair	(2660)	_____	_____	_____

8. Present Workers' Compensation Carrier: _____
9. Any claims in the past 5 years? Yes No **(Please request LOSS RUNS from your current carrier)**
10. Building Construction Type: _____ # of Stories: _____
 What Floor do you occupy? _____ Maximum # of Employees at the site: _____
 Located within a shopping center or mall? Yes No
11. Do you do any deliveries? Yes No If yes, what is the radius that you deliver? _____ miles
12. Any relatives employed? Yes No
 If yes, specify the relationship and whether or not coverage is desired

13. Hours of Operation: _____
14. Number of years in business: _____ Number of years at this location: _____
 If less than 5 years in business, provide years of previous experience: _____
15. Are you a member of the USRA? Yes No