CAP PHYSICIANS INSURANCE

Workers Compensation Quote Request Form

General Practice Information:

Business or Physician Name | Contact Name and E-mail

Business Type
☐ **Individual/Sole Proprietor** ☐ **Partnership** ☐ **Corporation**

Primary Practice Location

______________________________ State________ Zip Code______________

Phone ( ) | Fax ( )

Additional Practice Location

______________________________ State________ Zip Code______________

Phone ( ) | Fax ( )

Number of Years in Business | Federal Employer Identification Number (FEIN)

Workers Compensation Information:

Proposed effective date of coverage? ________________________________

Do you currently have a Workers Compensation Insurance policy?
☐ **Yes** ☐ **No**
If "Yes", who is your present carrier? ______________________ **Policy expiration date?** __________

Have you had any claims losses in the past three years?
☐ **Yes** ☐ **No**

Please list the number of employees you have: Full-time ________ Part-time________

What is the estimated annual gross payroll of your employees: $________________________________
(Sole Proprietors/Corporate Officers and Partners can be excluded from benefits. Do not include the payroll for those electing to be excluded.)

Please list the Sole Proprietor, Corporate Officers, and/or Partners to be excluded.

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Instructions for Return:

Upon completion, please fax this form to **213-576-8560**.
Your proposal will be sent to you via your preferred method marked below within 48 hours.

☐ E-mail: ________________________

☐ Fax: ________________________

CAP PHYSICIANS INSURANCE AGENCY, INC. • PROTECTING YOUR PRACTICE AND YOU
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