



**Workers' Compensation Quote Request Form**

**General Practice Information:**

Business or Physician Name		Contact Name and E-mail	
Business Type <input type="checkbox"/> <b>Individual/Sole Proprietor</b> <input type="checkbox"/> <b>Partnership</b> <input type="checkbox"/> <b>Corporation</b>			
Primary Practice Location			
		City _____	Zip Code _____
Phone (    )	Fax (    )		
Additional Practice Location			
		City _____	Zip Code _____
Phone (    )	Fax (    )		
Years of Experience in Medical Industry		Federal Employer Identification Number (FEIN)	

**Workers' Compensation Information:**

Proposed effective date of coverage? _____
Do you currently have a Workers' Compensation insurance policy? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b> <b>If "Yes", who is your present carrier? _____ Policy expiration date? _____</b>
Have you had any claims in the past three years? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>
Please list the number of employees you have. Full-time _____ Part-time _____
What is the estimated annual gross payroll of your employees? \$ _____ <i>(Sole Proprietors/Corporate Officers and Partners can be excluded from benefits. Do not include the payroll for those electing to be excluded.)</i>
Please list the Sole Proprietor, Corporate Officers, and/or Partners to be excluded. _____ _____

**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: \_\_\_\_\_