CAP PHYSICIANS INSURANCE®
License No. 0F97719

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, Owner-officers or Owner-Partners can be excluded from benefits. Do not include the payroll for those electing to be excluded.)

Please list the Owner-Officers or Owner-Partners to be excluded.

Upon completion, please fax this form to 213-947-4637. You may also send your completed form electronically. To do so, complete the form online and save the PDF to your desktop as a new document. Then, email the PDF to CAPAgency@CAPphysicians.com.