DHIA Daniels-Head Insurance Agency
Phone: (800)950-0551
Fax:(888)839-6107

WORKERS COMPENSATION INSURANCE QUESTIONNAIRE

NAME & ADDRESS OF APPLICANT:

_____

_____

_____

Contact Person: _____

Phone: _____

Fax: _____

Email: _____

LEGAL ENTITY: ☐ Sole Proprietor ☐ Corporation ☐ Partnership ☐ LLC ☐ Other: _____

Name of your current Workers Compensation Insurance Company: _____ **or** ☐ **N/A**

Effective Date Requested:_____ **Physical location:** _____

Description of Business / Services provided: _____

# of years in Business: _____ **# of Years Experience in this type of Business:** _____

Employer ID # (FEIN): _____ **Total Annual Revenue / Receipts:** _____

Total Number of Employees: # Full Time: _____ **# Part Time:** _____

Total Estimated Annual Remuneration / Payroll for Above Employees: $_____

Are Subcontractors/Independent Contractors Used? ☐**Yes** ☐**No** **Are they insured?** ☐**Yes** ☐**No**

OWNERS OR CORPORATE EXECUTIVE OFFICERS TO BE INCLUDED / EXCLUDED FROM COVERAGE:

Name	Title / Relationship	Ownership %	Duties	* *INCL / EXCL*	Annual Remuneration / Payroll

MEMBERS OF PARTNERSHIPS OR LLC's TO BE INCLUDED OR EXCLUDED FROM COVERAGE:

Name	Title / Relationship	Ownership %	Salaried or Equity Partner?	* *INCL / EXCL*	Annual Remuneration / Payroll

** Please indicate INCL if individual is to be included in coverage or EXCL if they are to be excluded*

Have you had any CLAIMS within the last three years? ☐ **Yes** ☐ **No**

[If "yes," please provide date, detailed description, and corresponding total amount of payments for each claim]

SIGNATURE: _____ _____

Owner, Officer or Partner **Date**