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Worker's Compensation Insurance Program

AGENCY NAME AND ADDRESS	COMPANY:	
	UNDERWRITER:	
	APPLICANT NAME:	
	OFFICE PHONE:	MOBILE PHONE:
PRODUCER NAME:	MAILING ADDRESS (including ZIP +4 or Canadian Postal Code)	YRS IN BUS:
CS REPRESENTATIVE NAME:		SIC:
		NAICS:
OFFICE PHONE (A/C, No, Ext)		WEBSITE ADDRESS:
MOBILE PHONE:	E-MAIL ADDRESS:	
FAX (A/C, No):	☐ SOLE PROPRIETOR ☐ PARTNERSHIP ☐ CORPORATION ☐ SUBCHAPTER "S" CORP ☐ LLC ☐ JOINT VENTURE ☐ TRUST ☐ OTHER	
E-MAIL ADDRESS:		
CODE: SUB CODE:	CREDIT BUREAU NAME:	ID NUMBER:
AGENCY CUSTOMER ID:	FEDERAL EMPLOYER ID NUMBER / NCCI RISK ID NUMBER	OTHER RATING BUREAU ID OR STATE EMPLOYER REGISTRATION NUMBER
PROPOSED EFFECTIVE DATE: ____/____/____	NORMAL EFFECTIVE DATE: ____/____/____	CWA MEMBER?

LOCATIONS
RATING INFORMATION

LOC #	STREET, CITY, COUNTY, STATE, ZIP CODE

LOC #	CLASS CODE	CATEGORY, DUTIES, CLASSIFICATIONS	ANNUAL PAYROLL	# EMPLOYEES F T / P T

POLICY INFORMATION

PART 1 - WORKERS COMPENSATION (States)	PART 2 - EMPLOYER'S LIABILITY	PART 3 - OTHER STATES INS		DEDUCTIBLES	AMOUNT/%	OTHER	COVERAGES		
							U.S.L. & H.		MANAGED CARE OPTION
	$ EACH ACCIDENT			MEDICAL					
	$ DISEASE-POLICY LIMIT			INDEMNITY			VOLUNTARY COMP		
	$ DISEASE-EACH EMPLOYEE						FOREIGN COV		