Workers Comp Information Sheet

1) Name _____ ( ) present client
1) Address_____
2) Phone # _____ Fax # _____
3) Type of business_____if RCFE,
   a. elderly ( ) DD ( ) Children ( )
   b. Licensed for _____ beds
4) Dementia/Alzheimer _____ Ambulatory _____ Non Ambulatory _____
5) Do you transport clients ( )Yes ( ) No If yes, how many times per week? Who drives?
6) # of years in Business _____ If newly purchased, date purchased _____
7) Locations:

   _____

   _____
8) Annual Payroll_____# of Employees ( ) ft
   ( ) pt
9) ( ) Single proprietorship ( ) Partnership ( ) Corporation **Federal ID #_____****
10) Previous Carrier_____Term_____Policy _____
11) Loss Run Available (**) PLS ask them to fax to us to get competitive rate w/ First Comp***

*** for each location*****