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 If not licensed **Need copy of licensing application (if New Business)**
4) Dementia/Alzheimer _____ Ambulatory _____ Non Ambulatory _____
5) Do you transport clients ( )Yes ( ) No If yes, how many times per week? Who drives?
6) Any client lifting done by your employees ( ) Yes ( ) No
7) # of years in Business _____ If newly purchased, date purchased _____
   Need copy of purchase agreement (if New Business)
8) Locations:
   _____
   _____
9) Annual Payroll_____# of Employees ( ) ft
   a. ( ) Includes payroll of principal (owner) ( ) pt
10) ( ) Single proprietorship ( ) Partnership ( ) Corporation **Federal ID #_____*
11) Relatives Employed: # _____Annual Payroll _____ Inc/Exc in line 9
12) Provides Board and Lodging for _____ (no of employees)
13) ( ) Owners desire coverage under WC . Payroll of owners _____
14) Previous Carrier_____Term_____Policy _____
15) Loss Run Available ( ) **This is the claim experience report (required by Carrier)**
16) Cancelled ( ) Reason for cancellation_____
17) Date of cancellation_____ **Need Lapse of Coverage letter ** (if lapsed policy is involved)**
18) If first WC, date of first hire _____(if operating without WC)
   Need Lapse of Coverage Letter (if lapse of policy is involved**
19) Independent Contractors Yes ( ) # of independent contractors _____
20) Duties of Contractors _____ **Need Independent Contractor Form**
21) Provisional Rate _____ Mod _____