

**Fax your completed form to 626.966.9882**

**Business/Group Information**

Company Name and DBA: \_\_\_\_\_

Primary Address: \_\_\_\_\_ City \_\_\_\_\_ CA, Zip \_\_\_\_\_

Primary Business Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_ Cell Number: \_\_\_\_\_

Proposed Effective Date: \_\_\_\_\_ Years in Business: \_\_\_\_\_ Federal EID: \_\_\_\_\_

Type of Business:  Sole Proprietorship  Corporation  LLC  Trust  Partnership  Subchapter  Joint Venture  
 Other \_\_\_\_\_

**Contact Information**

Owner: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

Claims Info: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

Inspection: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

Accounting: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

**Location Information**

Class Code: \_\_\_\_\_ Description Code: \_\_\_\_\_ Categories, Duties, Classifications: \_\_\_\_\_

Employees: Full Time \_\_\_\_\_ Part Time \_\_\_\_\_ SIC: \_\_\_\_\_ NAICS: \_\_\_\_\_

Estimated Annual Payroll: \$ \_\_\_\_\_ Rate: \$ \_\_\_\_\_ Estimated Annual Manual Premium: \$ \_\_\_\_\_

Location address different than above?  Yes  No If yes, please provide the address:

Address: \_\_\_\_\_ City \_\_\_\_\_ CA, Zip \_\_\_\_\_

More than one Location?  Yes  No How many? \_\_\_\_\_

**Individual Exclusions**

Please provide the following information for the person to be excluded:

Name \_\_\_\_\_ Location # \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Title/Relationship: \_\_\_\_\_

Duties: \_\_\_\_\_

Ownership %: \_\_\_\_\_ Class Code: \_\_\_\_\_ Payroll: \$ \_\_\_\_\_

More than one person to be excluded?  Yes  No

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**Additional questions**

Own, Operate or lease Aircraft/Watercraft?  Yes  No

Have past, present, or discontinued operations involving storing, treating, discharging, applying, disposing, or transporting of hazardous material?  Yes  No Do you lease employees to or from another employer?  Yes  No

Is applicant engaged in any other type of business?  Yes  No Written Safety Program in Operation?  Yes  No

Are Subcontractors used?  Yes  No (If yes, give % of work) \_\_\_\_\_% Group Transportation Provided?  Yes  No

Any employees under 16 or over 60 years of age?  Yes  No Seasonal employees?  Yes  No

Volunteer or donated labor?  Yes  No (If yes, please specify) \_\_\_\_\_

Employees with physical handicaps?  Yes  No Employees travel out of state?  Yes  No

Athletic Teams Sponsored?  Yes  No Physicals required after employment offer made?  Yes  No

Health Plans provided?  Yes  No Any employees perform to work for other businesses or subsidiaries?  Yes  No

Do Employees predominately work at home?  Yes  No (If any, how many) \_\_\_\_\_

Any tax liens or bankruptcy within the last 5 years?  Yes  No (If yes, please specify) \_\_\_\_\_

Any disputed and unpaid workers comp premium due from you or any other businesses?  Yes  No

(If yes, please specify) \_\_\_\_\_

**Carrier Information**

Current Carrier: \_\_\_\_\_ Current Premium: \$ \_\_\_\_\_ Dates of Coverage: \_\_\_\_\_

Retroactive Date: \_\_\_\_\_

Previous Carriers, If any: \_\_\_\_\_

Any Claims?  Yes  No (If yes, how many?) \_\_\_\_\_ Number of Open Claims: \_\_\_\_\_

Is carrier offering renewal?  Yes  No (If no, why?) \_\_\_\_\_

**Please provide the Following:**

Currently valued claims history from previous carriers

Current Certificate of Insurance

Other: \_\_\_\_\_