Brubaker & Associates

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Workers Compensation Proposal Request

Business Name:		Contact Name:
Business Address:		Email:
City:	State:	Zip Code:
Phone Number:	Fax Number:	Cell Phone Number:
Owners Name:	Title:	Percentage of Ownership:
Owners Name:	Title:	Precentage of Ownership:

Business Information

FEIN #	Requested Effective Date:

□ Sole Proprietorship □ Corporation □ Partners □ LLC □ Other

Business Description:

Number of Years in Business:	Number of Years in Industry:	Experience Mod.

Exclude Owners/Officers? □ Yes □ No

Employee Classifications

Employee Classifications:	Estimated Annual Payroll:	Number of Employees:
1		
2		
3		
4		
5		

Current Carrier Information

Current Insurance Carrier:	Expiration Date:	Premium:

Any losses in the last 5 years □ Yes □ No
If yes, please provide dates and description: