



**WORKERS' COMPENSATION
BALLPARK QUOTE FORM**



Your Name _____ FEIN/SS# _____
 Individual Corporation LLC Partnership "S" Corp Other _____
 Practice Name _____
 Mailing Address _____
 City _____ County _____ State _____ Zip _____
 Primary Practice Location Number of total locations of practice _____
 Street Address _____
 City _____ County _____ State _____ Zip _____
 Hours Practiced Per Week _____ Years in Practice (with Worker's Comp coverage) _____
 Web Address: www. _____
 Phone _____ Fax _____ Email Address _____
 Best Way to Contact Phone Email Fax
 Contact Person _____ Now Closer to My Expiration Date
 ➤ Attach a copy of your last declarations page(s):
 Current Carrier _____ Current Premium _____
 Current Limits _____ / _____ Current Deductible _____
 Current Expiration Date _____ Requested Effective Date _____

Number of employees. Do include ALL officers of a corporation in this count.

Name	Class Code	Name	Class Code	Name	Class Code
Total Number of Full-Time Employees		Total Number of Part-Time Employees		➤ Employees: Attach list of additional employee names.	

Gross Annual Staff Payroll	\$	Full Time Employees	#	Part-Time Employees	#
	\$	Myself			
GRAND TOTAL	\$	Exempt Me	Do Not Exempt Me		

Professional Services Plans
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