SafeTrak SOLUTIONS INC.

WORKERS COMPENSATION QUOTE QUESTIONNAIRE

Proposed Effective Date ________________

Company Name____EIN_______________________________________

Mailing Address__________________________________City______________________State_________Zip Code___________

Ph#__________________________________Fax#______________________________Email______________________________

Premises/Locations 1.____

2.____

3.____

Work. Comp. states of coverage ____

Deductible per claim ☐ $500 ☐ $1,000 ☐ $5,000 ☐ $10,000

Descriptions of activities/operations____

No. of Full Time Employees________ Total annual payroll ____________ No. of Part Time Employees ______ Total annual payroll ____________

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INDIVIDUALS INCLUDED/EXCLUDED***

Name_________________DOB___________Title___________Ownership %_________Duties_________________ ☐ Inc ☐ Excl.

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Name_________________DOB___________Title___________Ownership %_________Duties_________________ ☐ Inc ☐ Excl.

Attach additional pages if needed.

PRIOR CARRIER INFORMATION/LOSS HISTORY ☐ Loss Runs Attached

Year_______Carrier______________________Annual Premium______________# of Claims_______Amount Paid______________

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CONTACT INFORMATION

Inspection: Name______________________________Phone#___________________________Email________________________

Accounting Records: Name__________________________Phone#_________________________Email______________________

Claims Info: Name_____________________________Phone#___________________________Email________________________

Comments

*** Based on state laws, certain positions within an organization, such as sole proprietors and partners, may not be covered by the applicable workers' compensation law, and may elect to be brought under such law. Conversely, executive officers of corporations are usually considered to be employees, but may elect to be excluded from coverage.

Attach additional pages if needed.