# WORKERS' COMPENSATION QUESTIONNAIRE

## COMPANY INFORMATION

Company Legal Name: ______________________ Federal Tax ID#: ______________________ Year Established: __________

DBA: ______________________ SIC: ______________________ Multiple Locations: Yes / No

Business Address: ______________________ City: ______________________ Zip: __________

Business Phone: (     ) ______________ Business Fax: (     ) ______________

Contact Person: ______________________ Title: ______________________

Contact Phone: (     ) ______________ E-Mail: ______________________

Type of entity: (Check One) ___ C Corp ___ S Corp ___ Limited Liability Company ___ Partnership ___ Sole Proprietorship

Type of Business (Please describe your business operation): ______________________

## PARTNER/OFFICER INFORMATION

| Name of Partner / Officer | Title | % of Ownership | Exclude from Coverage |
|---|---|---|---|
| | | | Yes / No |
| | | | Yes / No |

## EMPLOYEE INFORMATION

Number of employees: Full Time: __________ Part Time: __________ Estimated Annual Payroll: ______________

* Please specify how much payroll is attributed to each employee type / class code:

| Employee Type / Class Code: | # of Employees: | Annual Payroll: $ | Current Class Rate: |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Is Medical Insurance Provided?: Yes / No Name of Carrier: ______________________

## WORKERS' COMPENSATION COVERAGE HISTORY

| Policy Year | Insurance Carrier | Policy Number | | | |
|---|---|---|---|---|---|
| *Current Carrier* | | | *Premium:* | *Renew Date:* | *Ex-Mod:* |
| 2007 - 2008 | | | | | |
| 2006 - 2007 | | | | | |
| 2005 - 2006 | | | | | |


Cloud, Minturn Associates
dba: CMA Insurance Services
CA License #0735758


**SEND COMPLETED FORM TO:**
**Fax (310) 755-6080 or Email: Service@CloudMinturn.com**


Phone (310) 316-3662
Fax (310) 755-6080
E-Mail: Service@CloudMinturn.com

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## OTHER INSURANCE COVERAGES

| Coverage | Carrier | Policy Number | Renewal Date |
| --- | --- | --- | --- |
| Building | Carrier: ________ | Policy Number: ________ | Renewal Date: ________ |
| Property | Carrier: ________ | Policy Number: ________ | Renewal Date: ________ |
| General Liability | Carrier: ________ | Policy Number: ________ | Renewal Date: ________ |
| Automotive | Carrier: ________ | Policy Number: ________ | Renewal Date: ________ |
| Umbrella | Carrier: ________ | Policy Number: ________ | Renewal Date: ________ |
| Employment Practices Liability | Carrier: ________ | Policy Number: ________ | Renewal Date: ________ |
| Errors & Ommissions | Carrier: ________ | Policy Number: ________ | Renewal Date: ________ |
| Directors & Officers | Carrier: ________ | Policy Number: ________ | Renewal Date: ________ |
| Health Insurance | Carrier: ________ | Policy Number: ________ | Renewal Date: ________ |
| Dental Insurance | Carrier: ________ | Policy Number: ________ | Renewal Date: ________ |
| Other | Carrier: ________ | Policy Number: ________ | Renewal Date: ________ |