

Cailor Fleming Insurance

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Youngstown, Ohio 44513

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Visit us at www.cailorfleming.com

Workers Comp. Questionnaire

COMPANY NAME (Include DBA's): _____
 Individual Partnership Corporation Other

FEDERAL ID #: _____

COMPANY ADDRESS: _____

TELEPHONE: ____ (____) _____ FAX: ____ (____) _____

EMAIL: _____

NUMBER OF EMPLOYEES: _____ YEARS IN BUSINESS: _____

<u>Annual Clinical/Lab</u> <u>Payrolls</u>	<u>Annual Clerical</u> <u>Payrolls</u>	<u>Annual Retail/Sales</u> <u>Payrolls</u>
\$ _____	\$ _____	\$ _____

Please list the name of your **Officers**, their titles, payrolls, job description, and whether they should be excluded from coverage. (Use additional sheet if necessary)

Name: _____	Title: _____	Annual Payroll: \$ _____	
Job Description: _____		Exclude: _____	Yes No

Name: _____	Title: _____	Annual Payroll: \$ _____	
Job Description: _____		Exclude: _____	Yes No

PREVIOUS CARRIER: _____

EXPIRATION DATE: _____

PREMIUM : \$ _____

HAS COVERAGE EVER BEEN CANCELLED OR DECLINED? YES NO

ANY LOSSES FOR THE PAST THREE YEARS? (If yes, please attach loss runs) YES NO

COMMENTS: _____

Any person who knowingly and with the intent to defraud any insurance company or another person files and an application containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects the person to criminal and (NY: substantial) civil penalties.

SIGNATURE: _____ **DATE:** _____

PRINT NAME: _____