Cailor Fleming Insurance
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PO Box 3989
Youngstown, Ohio 44513

(330) 782-8068
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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: _____

Annual Clinical/Lab Payrolls	Annual Clerical Payrolls	Retail/Sales Payroll
$	$	$

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: _____