Associate with Confidence and Trust

ACT Insurance Services

WORKERS COMPENSATION INSURANCE QUESTIONNAIRE

Date: _____ Policy Effective Date: _____ Producer: _____

Named Insured: _____DBA: _____

Phone # _____ Fax# _____

Contact Person: _____ Website: _____

Number of Years in Business: _____ Date First Employee was hired (new venture only): _____

Entity: ❑ Corporation ❑ Individual ❑ Partnership ❑ LLC

Federal Employer ID#: _____

Location: _____

_____

Mailing Address (if difference from the Location): _____

_____

Nature of Business and Description of Operation: _____

Officers' Name	Title	% of ownership ***Ownership MUST be accurate & total up to 100%***
_____	President	_____
_____	Secretary	_____
_____	Treasurer	_____

Classification	# of employees Full Time / Part Time	Estimated Annual Payroll
_____	_____/_____	$_____
_____	_____/_____	$_____
_____	_____/_____	$_____

	Prior Insurance Company	Policy Number	Expiration Date	Payroll	Premium
Current Yr.	_____	_____	_____	$_____	$_____
1st Prior Yr.	_____	_____	_____	$_____	$_____
2nd Prior Yr.	_____	_____	_____	$_____	$_____
3rd Prior Yr.	_____	_____	_____	$_____	$_____

**** Please provide copy of loss run for the past 3 years.

ACT Insurance Services Inc.
1322 Potrero Grande Dr., Rosemead, CA 91770
Tel: (626) 307-0628|Fax: (626) 307-8692
License #0H52436 | Website: ACTinsurance.net

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WORKERS COMPENSATION INSURANCE QUESTIONNAIRE --- CONTINUED

- Paid sick leave: ❑ Yes ❑ No
- Paid Vacation: ❑Yes ❑ No
- Retirement/Pension Plan: ❑ Yes ❑ No
- Safety Program . Injury Illness Prevention Program: ❑ Yes ❑ No
- Safety meeting held for all employees: ❑ Yes ❑ No
  If yes, how often? ❑ Monthly ❑ Quarterly ❑ Semi Annually ❑ Annually
- Employment Application : ❑ Yes ❑ No
- Reference Checks: ❑ Yes ❑ No
- Volunteer Labor Used: ❑ Yes ❑ No
- Temporary Labor Used: ❑ Yes ❑ No
- Hours of operation : _____ A.M. / P.M. to _____ A.M. / P.M.
- # of daily shifts: _____
- Any Forklift exposures: ❑ Yes ❑ No If yes, # of Forklift: _____
  # of Driver(s):_____ Forklift Certified: ❑ Yes ❑ No
- Any delivery: ❑ Yes ❑ No Number of Driver(s): _____
  Number of Vehicles: _____ Radius: _____ miles.
  Frequency of delivery: ❑ Daily ❑ Weekly ❑ Other _____
- Employees take vehicles home : ❑ Yes ❑ No
- How often vehicle maintenance are performed: _____
- Any travel out of state? ❑ Yes ❑ No If yes, # of employees who travel:_____
  Where would the employees be traveling to: _____
  Are the traveling oversea: ❑ Yes ❑ No If yes, where:_____
  Frequency_____ Purpose: _____
- Do you have group medical Insurance? ❑ Yes ❑ No
  If yes, name of insurance carrier: _____ Group number: _____

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