

Workers compensation application



DBA:		Owner:	
Contact:		EIN:	
Email:		CSLB license # & type:	
Cell:		Current WC expires:	
Mailing:		Today's date:	
City:	State: CA Zip:	<input type="checkbox"/> Sole <input type="checkbox"/> Corp <input type="checkbox"/> LLC	Years w insurance:
Total employees:	Total owners:	Source:	SP code:
Employee info			
Class code	Duties	Total payroll	Number of full & part time
Owner info			
Owner name		Ownership percentage	Title
Insurance history & coverages requested			
2017 & current carrier:		Payroll:	Premium: \$
2016 carrier:		Payroll:	Premium: \$
2015 carrier:		Payroll:	Premium: \$
2014 carrier:		Payroll:	Premium: \$
2013 carrier:		Payroll:	Premium: \$
Narrative of operations			

Providing false information may void or reduce coverages. The insured certifies the above is true and correct to the best of their knowledge.

Insured _____ date _____