P.O. Box 970
Covington, LA 70434-0970

985.892.1500 office
985.893.2590 fax

A NAME YOU CAN TRUST.

WORKERS COMPENSATION QUESTIONNAIRE

1. Named Insured ______________________________

2. Mailing Address ______________________________

   Physical Address _____________________________

3. Phone # _____________________________________

4. S.S.# _______________ or FEIN# ______________

5. Description of Operations ______________________________________

____

6. Years in Business ________ Experience __________________________

7. Name of Owners % Ownership S.S. # DOB

Name of Owners	% Ownership	S.S. #	DOB

8. Owners: Included or Excluded

   # Employees ____________
   # Part Time____________ Full Time_______________
   Annual Payroll ________________________________
   (If not all same classification – breakdown payroll by class)

9. Method of Payroll: W2 ___or 1099 ____

10. Prior Coverage ____

    Losses____