New Business Quote Questionnaire

CNA

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SMALL BUSINESS

WORKERS' COMPENSATION QUOTE ONLY

CLIENT INFORMATION

Company Name _____ Agency Name _____

Contact Name _____ Contact Email _____

Mailing Address _____ City _____ State_____ Zip _____

Telephone (_____)_____-_____ Facsimile (_____)_____-_____ Website _____

Years in Business _____ Number of Employees: Full Time _____ Part Time _____

Annual Payroll $_____ Gross Annual Sales for All Locations $_____

Federal Employer ID (FEIN) _____ NY Unemployment Number _____ or NJ Tax ID _____

Legal Entity (Corporation, Partnership, LLC, Sole proprietor, etc.) _____

Effective Date _____/_____/_____ Expiration Date _____/_____/_____

CURRENT / PAST INSURANCE EXPERIENCE

Do you currently have a business insurance carrier? ☐ Yes ☐ No

If yes, please provide previous carrier information for all lines of business or three years managerial experience

_____

Any Losses in The Last 3 Years? ☐ Yes, Loss Runs to Follow ☐ No

If yes, please describe and provide loss runs from your current insurance company below or on a separate sheet (if necessary)

_____

Date of Loss: _____/_____/_____ Loss Description: _____

Loss Amount: _____ ☐Open ☐Closed

WORKERS' COMPENSATION

State Required Limits ☐ Yes ☐No (If no, please provide limits to be quoted in the following questions)

EMPLOYER'S LIABILITY LIMITS

Each Accident $_____ Disease Policy Limit $_____ Disease Each Employee $_____

Location #1

Address (If different than mailing) _____ City _____ State _____ Zip _____

Number of Employees: Full Time _____ Part Time _____

Class Code/Description of Duties _____ Payroll _____

Class Code/Description of Duties _____ Payroll _____

Location #2

Address (If different than mailing) _____ City _____ State _____ Zip _____

Number of Employees: Full Time _____ Part Time _____

Class Code/Description of Duties _____ Payroll _____

Class Code/Description of Duties _____ Payroll _____

Are all of the above locations owned by the company name listed on page 1? ☐ Yes ☐ No

If no, please provide the following information on each entity):

Name _____ FEIN _____ # of Locations _____

EXCLUSION/ELECTION INFORMATION

List name and title of owners and indicate whether they should be included/excluded from Worker's Compensation coverage

Name	Title	Incld/Excld	Payroll

Does your company hire subcontractors? ☐ Yes ☐ No

If yes, are Certificates of Insurance required for all subcontractors? ☐ Yes ☐ No

If yes, are Employer Liability limits required equal or exceed your limits? ☐ Yes ☐ No

Does your company utilize a return-to-work (RTW) program? ☐ Yes ☐ No

SIGNATURE

I certify that the above information is accurate as provided.

_____ _____

Signature Date

SUBMIT THIS APPLICATION TO
mdiette@flag4u.com or fax to (954) 724-7445.