Top Contractors
INSURANCE SERVICES, INC.
145 Vallecitos De Oro Suite #206 License # 0H18147
Phone: 888-710-TOPS **Fax: 866-323-5675**
"Your one sTop shop for all of your Insurance Needs"

Work Comp Questionnaire

CONTRACTORS LICENSE #: _____

FEIN_____YRS IN BUSINESS:_____

YRS EXPER._____EXMOD: _____

WORKER'S COMP INSURANCE HISTORY

3 years	Insurance Co.	Effective date's	Policy #	Premium
CURRENT				
1 YR PREV.				
2 YR PREV.				

IF YOU DO HAVE THE LOSS RUNS PLEASE FAX THEM BACK WITH THIS APPLICATION

If you would like your agent to request the loss runs on your behalf please check Yes___ No___

LOSSES all losses /claims require a written description, including nature of injury cause and current status.

DATE OF OCCURANCE	DESCRIPTION OF OCCURANCE OR CLAIM	DATE OF CLAIM	AMOUNT PAID

EMPLOYEE INFORMATION

Class Code Current Rate	Type of work	# of Employees	Hourly pay	Est. Annual Payroll	

BENEFITS PROVIDED-FOR ALL ELIGIBLE EMPLOYEES YES___ NO___

		% Paid By Employer	% of Participation
Group Health	☐ Yes ☐ No	_____	_____
Paid Sick Leave	☐ Yes ☐ No	_____	_____
Vacation	☐ Yes ☐ No	_____	_____
Retirement	☐ Yes ☐ No	_____	_____

Name of Health Care Provider: _____

Provide Name of Clinic, Physician, or Emergency Room for Work Place Injury: _____

TYPE OF WORK (next 3 lines should each total 100%)

New Construction: RESIDENTIAL_____ __ % INDUSTRIAL_____ _% COMMERCIAL_____ _% = 100%

Remodeling RESIDENTIAL_____ __ % INDUSTRIAL_____ _% COMMERCIAL_____ __% = 100%

Repair Work RESIDENTIAL_____ __ % INDUSTRIAL_____ _% COMMERCIAL_____ __% = 100%

DESCRIBE YOUR OPERATIONS _____

_____

DO YOU EVER DO ANY EXTERIOR WORK OVER 3 STORIES IN HEIGHT _____

ANNUAL GROSS RECEIPTS: _____ SUB OUT COST: _____

DESCRIBE THE TYPE OF WORK SUB-CONTRACTED _____

AVAERAGE HOURLY WAGE: F/T $ _____ P/T $_____

THIS APPLICATION CONTAINS THE INFORMATION NEEDED TO START YOUR POLICY. IN SOME CASES IT MAY BE NECESSARY TO TRANSFER THIS INFORMATION TO ONE OR MORE CARRIER SPECIFIC FORMS. IF THAT IS NECESSARY WE WILL COMPLETE THEM FOR YOU AND SIGN ON YOUR BEHALF WITH THE INFORMATION FROM THIS APPLICATION.

CLIENT AGREES TO INDEMNIFY AND HOLD HARMLESS TOP CONTRACTORS INSURANCE, ANY OF ITS EMPLOYEES AND AGENTS, ALONG WITH ANY OF ITS AFFILIATED COMPANIES FROM AND AGAINST ANY AND ALL CLAIMS ARISING OUT OF OR RELATION TO ANY ALLEGED FAILURE TO ACT ON THE PART OF THE CLIENT WHICH RESULTS IN ANY CLAIM, DEMAND, ACTION, OR CAUSE OF ACTION AGAINST TOP CONTRACTORS INSURANCE SERVICES INC, OR ITS AFFILIATED COMPANIES.

_____ _____ _____

SIGNATURE: PRINT NAME DATE