7200 Corporate Center Drive, Suite 316 – Miami, FL 33126
877-463.9431 – Fax 305.629.7809 – Email: gmail@allcityins.com

# WORKERS' COMPENSATION INFORMATION FORM

## ❶ GENERAL INFORMATION

PROSPECT INSURED NAME: ____________________________________ CONTACT NAME: _______________________

ADDRESS: ____________________________________ CITY: ________________ STATE: _____ ZIP: ____________

TELEPHONE: ____________________ FAX: __________________ EMAIL: ____________________

## ❷ BUSINESS INFORMATION

TYPE OF ENTITY: ☐ INDIVIDUAL ☐ CORPORATION ☐ "S" CORPORATION ☐ PARTNERSHIP ☐ JOIN VENTURE
☐ LIMITED LIABILITY ☐ OTHER: ___________________________________________

YEAR BUSINESS ESTABLISHED: ___________ YEARS EXPERIENCE: _________ FEDERAL TAX ID NO. ___________________

BUSINESS DESCRIPTION: ____________________________________________________________________________

________________________________________________________________________________________________

PRIOR INSURANCE COMPANY NAME: _____________________________________________

POLICY EXPIRATION DATE: ____________ CLAIM IN THE LAST 5 YEARS: ☐ YES ☐ NO

## ❸ RATING INFORMATION

COMPLETE BELLOW OR ATTACH COPY OF YOUR CURRENT POLICY DECLARATION'S PAGE AND CLASSIFICATION INFORMATION.

| CLASS CODE | DESCRIPTION, DUTIES, CLASSIFICATIONS | # F/T EMPL.. | # P/T EMPL. | ESTIMATED ANNUAL REMUNERATION FOR NEXT POLICY PERIOD |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**PLEASE FAX THIS FORM WITH THE ADDITIONAL INFORMATION (IF AVAILABLE) TO 305.629.7808 OR BY EMAIL TO GMAIL@ALLCITYINS.COM**