

Workers Compensation Quote Form

Please Print or Type Information

1-800-632-4591
(616) 454-8257
Fax: (616) 454-6549



_____/_____/_____
Firm Name Date

Contact Person

Address

City State Zip

(_____) (_____) _____
Telephone Fax

Years in Business Federal Tax ID Number Previous Workers Compensation Carrier

Individual Partnership Corporation (PC) Other Effective Date of Policy _____

Note: Sole proprietors are automatically excluded from WC coverage

If Individual and married, Does Spouse Work in the Office? Yes No

Partnership or Corporation

Do You Opt to Exclude Partners / Officers? Yes No

If Yes, List name. Partner /Corporate Title and Percentage of Ownership Below:

Provide Estimated Annual Gross Payroll by Class:

Code	# of Employees	Class	Payroll
8810		Clerical	\$ _____
8820		Lawyers	\$ _____
8832		Dentists	\$ _____
8803		CPA's	\$ _____
8601		Engineers	\$ _____
9015		Janitorial	\$ _____
		Officers / Partners / Spouce	\$ _____

Names of Partners / Officers Being Included on Last Line Above:

This form does not guarantee coverage. Additional information may be required.