Nextassure Insurance Service
Next Level of Insurance

Date

Application – Worker's Compensation*

Name of Business FEIN #

DBA Name

Mailing Address City State Zip

Location Address If mailing is different

Contact Name Contact Work Phone Contact Fax

Contact Cell # Contact Email

Type of Business

Corporation ☐ Individual ☐ Partnership ☐ LLC ☐

Select Nature of Business Allied Health Years in Business

Full-Time Employees Part-Time Employees

Number of Owners / Officers Included Excluded

WorkComp class code if known

Est. Annual Payroll For: Full-Time Part-Time

Maximum No. of Employees Working at One Location Hours of Operation *(From/To)* /

Is your operation is in multiple state? Yes ☐ No ☐ If Yes, please provide all states payroll and class codes

State	Annual Payroll Full Time Emp	Annual Payroll Part Time Emp	WorkComp Class Code If Known

(At one time at one location)

Will you be able to provide the prior carrier and loss information? Yes ☐ No ☐

Is the loss ratio (Average Annual Losses/Quote Premium less than 40%? Yes ☐ No ☐

Do you have any claims on your WC policy in the last 3-5 years? Yes ☐ No ☐

*Non-binding