



Workers' Compensation Quote Request

Click to submit this form by e-mail:

www.AnchorWestInsurance.com

(888) 388-5655 toll free | (888) 288-5486 fax

CA Broker License #: 0G72981

Named insured _____ Contractor's License # _____

Owner's name _____ Contact's name _____

Phone #: _____ Cell # _____ Fax # _____

Email: _____ Preferred method of contact: Phone Fax Email Mail

Mailing address: _____

Physical/Premise address: _____

Business entity: Sole proprietorship Partnership Corporation LLC Other: _____

Business License # _____ FEIN: _____ OR SSN: _____

Hours of operation: _____ Out of state travel? Yes No

Number of years in business _____ Number of years experience _____

Ownership Information:

Full Name	Include or Exclude?	Date of Birth	Percent of Ownership	Official Title	Active in the field?
	<input type="checkbox"/> Inc <input type="checkbox"/> Exc				<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Inc <input type="checkbox"/> Exc				<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Inc <input type="checkbox"/> Exc				<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Inc <input type="checkbox"/> Exc				<input type="checkbox"/> Yes <input type="checkbox"/> No

Describe, in detail, the operations performed by you and your employees:

THIS IS NOT AN APPLICATION; IT IS ONLY A PRELIMINARY INFO SHEET FOR A QUOTE.
ADDITIONAL INFORMATION MAY BE REQUIRED.

Maximum height in feet: _____ Type of work: _____

Scaffolding (your own) Scaffolding (leased/rented) Ladder Scissor Lift

Maximum depth in feet: _____ Type of work: _____

Do you use subcontractors? Yes No % of work subcontracted? _____

Average annual gross receipts? \$ _____

The following is the basis of the quote, and must be provided:

Class Code or Description (please be as complete as possible)	Expected Annual Payroll	Average Hourly Wage	Number of employees	
			Full Time:	Part Time:
	\$	\$		
	\$	\$		
	\$	\$		
	\$	\$		

Have you had prior coverage during the last five years? Yes No

NOTE: 5 years of Loss run reports will be required.

Have there been any losses or claims in the last five years? Yes No

Is your coverage currently in force? Yes No. If yes, what is the Expiration date: _____

Current Carrier: _____ Current experience modification: _____

Prior 4 years premium: Current Premium: \$ _____ | 20____: \$ _____

20____: \$ _____ | 20____: \$ _____

Do you offer any of the following benefits?

Group Health Paid Sick Leave Paid Vacation Retirement/Pension Plan Other: _____

Do you use a specific clinic, physician, or emergency room? _____

Do you use any of the following hiring practices?

Employment applications Reference checks Motor vehicle reports

Volunteer labor Temporary labor Drug/substance abuse testing

Pre/post employment physical Back testing Other: _____

Do you use any of the following safety programs or precautions?

Injury & Illness Prevention Plan Safety Incentive Plan Employee Orientation

Formal Written Accident Report Safety training/meetings Personal Protection Equipment

Post accident drug testing Other _____

Date

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