LANDY Insurance　　NextHome

Workers Compensation Indication Questionnaire

Please Complete All Areas. Put "N/A" or "0" if Not Applicable.

Contact Information

Name of Business: ____

Principal Contact Name: ____

Street Address: ____

Mailing Address: ____

City, State, Zip: ____

Phone: _________________　　Fax: ________________

Email Address: _______________________________

Business Activities

Type of Business: (Sole Prop, S-Corp, LLC, etc.)_____________

Description of Business/Services: _________________________

Date Business Was Established: __________________________

Primary State Where Business is Located: ___

Payroll Information

(Do Not Include Payments to Owners or Sub Contractors unless coverage is desired or required for them)

Annual Gross Payroll: ___________

Employee Classification and Payroll by State:

Classification (Example: Tax Preparer, Administrative Assistant, etc)	No. of Employees	Annual Payroll	State
_______________________	___	_____________	___
_______________________	___	_____________	___
_______________________	___	_____________	___
_______________________	___	_____________	___
_______________________	___	_____________	___

Coverage Information

Do you currently carry Workers Compensation Insurance? Yes____ No____

Current Carrier: ____________________________________

Expiration Date: ____________________________________

Premium: ____

Have You Had Any Policy or coverage declined, cancelled or non-renewed during the prior three years, or any claim?
(If yes please provide the date, description and amount paid below)

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Authorized Signature of Applicant　　**Date**

Please fax the completed Questionnaire to 800-344-5422 or email it to landy_insurance@landy.com.
For questions and information, contact us at 800-336-5422 or at johnt@landy.com

This request for a premium quotation does not constitute nor bind insurance coverage in any way.

The Herbert H. Landy Insurance Agency
75 Second Ave. Suite 410
Needham, MA 02494
PH: 800-336-5422 or visit on the web ay www.landy.com