RLIPack® Workers Compensation Quote Information

Proposed Effective Date:_____ Email:_____ Phone Number:_____

Named Insured (Your full business or corporate name, including any DBA's): _____

Mailing Address: _____ Website: _____

Entity Type: ☐ Sole Proprietor ☐ Partnership ☐ Corporation ☐ LLC/LLP ☐ Other: _____

Current Carrier: _____

Audit Contact Name: _____

Loss History: ☐ No losses (Note: Have insured sign a statement of no losses if bound.)
☐ 5 year Loss runs attached. (Note: Five year loss history required to qualify for UPCIP.)
☐ Quote subject to acceptable loss history.

Federal Employers ID Number: _____

NCCI Risk ID Number (If available): _____

Other Bureau ID or State Employer Registration Number (If available): _____

Experience Mod: _____

Does the applicant own, operate or lease aircraft? ☐ Yes ☐ No

Employers Liability Limits

☐ $100,000 Each Accident / $500,000 Policy Limit Disease / $100,000 Each Employee Disease
☐ $500,000 Each Accident / $500,000 Policy Limit Disease / $500,000 Each Employee Disease
☐ $1,000,000 Each Accident / $1,000,000 Policy Limit Disease / $1,000,000 Each Employee Disease
Expiration Date: _____

Optional Coverages

Waiver of Subrogation ☐ Blanket ☐ Specific
☐ Voluntary Compensation
☐ U.S.L. & H.
☐ Other Coverage: _____

Estimated Payrolls

Class Codes/Duties	# of Employees	Estimated Payroll

Officer, Partners & Individuals To Be Included Or Excluded (If including, please add payroll to appropriate class code above.)

Name	Title	Class Code/Duties	Include Or Exclude	Ownership Percentage