

Please fax completed questionnaire to (310) 321-6563
Workers' Comp Questionnaire

2011

I am interested in: improving broker service cost savings improving carrier quality other: _____

I am interested in KBI's multi-line discount: Yes No

I am interested in a price comparison for: Group Health Business Auto Employment Practices

General Liability If yes, please provide renewal date: _____ current carrier: _____

Named Insured (**legal name**): _____

(**DBA**): _____

Business Address: _____

City: _____ Zip: _____

Business Phone #: (____) _____ Business Fax #: (____) _____

Federal ID #: _____ --- _____ Years in business: _____

Multiple locations: Yes No Website: _____

Please indicate type of entity: corporation sole proprietorship partnership limited liability company

Name of Partners or Officers	Title	% of ownership	Exclude from coverage
_____	_____	____%	Yes <input type="checkbox"/> No <input type="checkbox"/>
_____	_____	____%	Yes <input type="checkbox"/> No <input type="checkbox"/>

Employee Payroll

Estimated **Annual Payroll**: \$ _____

**Please specify how much payroll is attributed to each class code.*

Class Code: _____ Annual Payroll: _____

Class Code: _____ Annual Payroll: _____

Class Code: _____ Annual Payroll: _____

Health Benefits

Is group **Health Insurance** offered? Yes No

Name of carrier? _____

Number of employees on the plan: _____

Operations

Any delivery? Yes No # Vehicles _____ # Drivers _____

Workers' Comp Coverage History

What is your **Annual Renewal Date**? _____

Number of **Claims** in the past 4 years? _____

Policy Year: _____ **Insurance Co.** _____ **Policy Number :** _____

2007-2008 _____

** KBI will not contact your current broker / agent.*

2008-2009 _____

2009-2010 _____

2010-2011 _____

Please sign below granting us authority to order loss runs on your behalf.

Name of person to contact regarding your workers' comp info:

_____ Ph: (____) _____

E-mail: _____

X _____

OWNER / OFFICER SIGNATURE

Please be advised: In order for KBI to market your account with the top carriers, this questionnaire needs to be filled out entirely. Incomplete questionnaires will be returned with a request for the missing information. Please feel free to call us if you are not sure or need help.

Please note: The majority of the carriers we work with have a min annual premium requirement of \$950.