

Date Received _____ Need By _____

Commercial Quote Sheet – Work Comp

Named Insured _____

Mailing address _____

Physical address _____

Phone Number _____ Email address _____

Web address _____

EIN _____ Organization type __ Sole Proprietor __ LLC __ Partnership __ Other

All Names of Business Owners _____

Year Business Established _____ Years of Experience _____ Any Losses in last 3 years __ Y __ N

Type of Insurance Quote Requested _____

Current Carrier _____ Expiration Date _____

Detailed description of operations: _____

Workers Compensation Section

Complete Business Name _____

FEIN _____ Does the above entity own any other companies? If so list complete names and FEIN's _____

List states worked in _____

Job Description (one job type per line)

Fax back to 972-681-7601 / Email to S.Latham@mulleninsurance.com

Date Received _____ Need By _____

Annual payroll per job type _____

List of Owners _____

Include or Exclude Owners? ___Y___N

Comments _____

Fulltime Employees # _____ Part-time employees # _____ Number of Subs _____