Lawyers Workers' Compensation Program Questionnaire

Full Name of the Employer _____

Requested Effective Date of Insurance _____

Business Type (Corporation, Partnership, LLC, etc.) _____

If a corporation, in what state are you incorporated? _____

Date of Incorporation _____

FEIN Number for Each Employer to be covered _____

Work Location (Physical Address) _____

Mailing Address _____

_____

Phone Number _____ Fax Number _____ E-mail Address _____

Have you ever purchased Workers' Compensation Coverage? ☐ Yes ☐ No

If no losses in the last 5 years, please indicate "None" _____
If you have had losses, please provide a loss summary

Have you been declined for coverage within the last 12 months? ☐ Yes ☐ No
If yes, please provide reason _____

_____

Please list your estimated annual payrolls by work classification:
Your Payroll _____
Clerical Payroll _____
Other (Please describe) _____

Do you carry Disability Benefits coverage? ☐ Yes ☐ No
This coverage is required in NY State

Do you want a quote for Disability Benefits coverage? ☐ Yes ☐ No

Is the applicant engaged in any other type of business? ☐ Yes ☐ No
If yes, please describe _____

Does the applicant primarily engage in personal injury or criminal cases? ☐ Yes ☐ No

Do the applicant's employees travel outside of the home state on a regular basis? ☐ Yes ☐ No

Does the applicant or any officer own, operate, borrow or lease any aircraft or any watercraft exceeding 25 feet in length? ☐ Yes ☐ No

Does the applicant currently have Workers' Compensation Coverage in force? ☐ Yes ☐ No
If yes, what is the expiration (or renewal) date for that coverage? _____

Print Name _____

Once you return the completed questionnaire we will provide you with confirmation of your estimated annual premium and instructions if you wish to bind coverage. Thank you for your interest!

Please return by faxing to: **800-214-9486 OR**
E-mail by clicking the "**Submit**" button
If you have any questions, please contact **ruth.oconnor@jltfacilities.com**

Print Form *Reset Form* *Submit*