

GLOBAL INSURANCE AGENCY, LLC

514 Westfield Avenue

Elizabeth, NJ 07208

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Sales Rep.

WORKER'S COMPENSATION INSURANCE APPLICATION

Date: _____

COMPANY'S INFORMATION

Legal Business' Name: _____

Entity Type: Sole Proprietorship _____ LLC _____ Corporation _____ Partnership _____ Other: _____

Employer Identification Number (EIN) or Tax Payer Number: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ E-mail: _____

Year Business started: _____ Owner's Years of Experience: _____ Owner's Managerial Experience: _____

Nature of Business: _____

Briefly describe the work you do: _____

Is this a Home based Business: _____

Does your company manufactures, distribute, sale and/or import/export products? _____ If so, explain in details the products type and your company's role (List products).

OWNERS/OFFICERS

Owner/Officer 1

Owner/Officer 2

Owner/Officer 3

Name: _____

Name: _____

Name: _____

Title: _____

Title: _____

Title: _____

Address: _____

Address: _____

Address: _____

Date of Birth: _____

Date of Birth: _____

Date of Birth: _____

Social Sec. No.: _____

Social Sec. No.: _____

Social Sec. No.: _____

Phone: _____

Phone: _____

Phone: _____

LOCATIONS INFORMATION

Location 1: Address: _____ City: _____ State: _____ Zip: _____

Location 2: Address: _____ City: _____ State: _____ Zip: _____

Location 3: Address: _____ City: _____ State: _____ Zip: _____

FINANCIAL INFORMATION

Annual Gross Sale/Receipts: Last 12 months _____ Projected for next 12 months _____

EMPLOYEES INFORMATION

No. of Full Time Employees: _____ No. of Part-time Employees: _____ No. of 1099 Employees: _____

If sub-contractors are used percentage of Sales/Receipts derived from sub-contractor: _____

Annual Payroll: Last 12 months _____ Projected for next 12 months _____

Please provide employee categories and annual payroll expenses per each category (Example: Clerical, Warehouse, Executives, etc)

Category/Class	No. of Employees	Annual Payroll
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

CURRENT INSURANCE INFORMATION

Is the company currently insured? _____ if so, please provide the below information:

Insurance Company's Name: _____ Policy #: _____

Policy's Expiration Date: _____ Current's Coverage Limit: _____

Applicant's Name and Title Signature & Date

Sent/Referred by: _____ send quote to: _____
Print name and number (Fax # or E-mail)