



P.O. Box 793, Teton Village, WY 83025  
 800.746.0048 toll free • 307.733.7439 fax • www.vanoppenco2.com  
 Insurance and Risk Control Solutions for Environmental Service Firms

## WORKERS' COMPENSATION QUESTIONNAIRE

Please fax or mail this form back to us. Fields with an asterisk (\*) need to be filled.

1. Company Name:\*

2a. Mailing Address:\*

2b. City, State, Zipcode:\*

3. Please advise what payroll classifications appear on your current policy and provide payroll information (EXCLUDE ACTIVE OWNERS) – Please note state which coverage applies:

	Classification Code #/State	Payroll Next 12 Mos.	Payroll Last 12 Mos.
1			
2			
3			
4			
5			

4. FEIN #\*

5. Please identify the owners and officers of your company by title and percentage of ownership:\*

6. Please identify those owner who wish to be excluded from Workers' Compensation coverage:

7. Please identify your Workers' Compensation insurer for the past five years and policy number:

	Year (yyyy)	Insurer	Policy #
1			
2			
3			
4			
5			



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8. Have you ever had a loss?

Yes  No

9. Do you presently have an employee health insurance plan?

Yes  No

If Yes, please identify insurer:

10a. Please list all states where you have resident employees below.

10b. Do you have any employees which travel outside of the Country on business?

Yes  No

11. Any over the water exposure or USL&H needed:

Yes  No

**Additional information requested – Please send the following:**

1. Four years formal insurance reports or a detailed letter confirming loss history and agreeing to obtain these reports as soon as possible.
2. A photocopy of information from your current insurer which identifies your current experience modification.
3. A copy of your Health and Safety Plan.

**I CERTIFY THAT THE STATEMENTS ABOVE ARE CORRECT AND TRUE.**

Signature over printed name of person completing the questionnaire:\*

Phone Number (ex: 000-000-0000):\*

E-mail:\*

Date (mm/dd/yyyy):\*