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 return this form by fax, mail, or email.

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 #/Slate	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:

	Expiration Date (mm/dd/yyyy)	Insurer	Policy #
1			
2			
3			
4			
5			

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):