GRACEY-BACKER, INC.
Insurance since 1925

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WORKERS' COMPENSATION INSURANCE FAX-BACK QUOTE FORM

Email to INSURANCE@GBIFL.COM or Fax to 561-265-0034

Full Legal Name of Business: _____

Business Address: _____

_____

FEIN Number: _____

Contact Phone: _____ Email: _____

Legal Entity: ☐ Individual ☐ Corporation ☐ Partnership ☐ LLC ☐ Other

Requested Effective Date: _____

Number of Employees (including doctors): Full-Time _____ Part-time _____

Annual Gross Payroll for all Emplyees, excluding officers? _____

Annual Gross Payroll for officers only (if included)? _____

List any Officers of the Business:

_____ _____ Included _____ Excluded

_____ _____ Included _____ Excluded

_____ _____ Included _____ Excluded

_____ _____ Included _____ Excluded

_____ _____ Included _____ Excluded

Are employee health plans provided? ..... Y / N

Are Employees under 16 or over 60 years of age? ..... Y / N

Any part time or seasonal employees? ..... Y / N

Do you have any independent contractors? ..... Y / N

Name of Current Insurance Carrier: _____

Any Claims in the past 5 years? ..... Y / N

If you have additional practice locations, please list them on an additional page.