



GRACEY-BACKER, INC.
EST. 1925
INSURANCE

**WORKERS' COMPENSATION INSURANCE
QUESTIONNAIRE**

Email to INSURANCE@GBIFL.COM or Fax to (561) 265-0034
For questions, please call (800) 272-6055

Name of Business: _____

Business Address: _____

FEIN Number: _____

Contact Phone: _____ Email: _____

Legal Entity: Sole Proprietor Corporation LLC Partnership Other

Requested Effective Date: _____

Name of Current Insurance Carrier: _____

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

Annual Gross Payroll for Employees (excluding Officers): _____

Annual Gross Payroll for Officers Only (if included): _____

List any Officers of the Business:

_____	<input type="checkbox"/> Included	<input type="checkbox"/> Exempt
_____	<input type="checkbox"/> Included	<input type="checkbox"/> Exempt
_____	<input type="checkbox"/> Included	<input type="checkbox"/> Exempt
_____	<input type="checkbox"/> Included	<input type="checkbox"/> Exempt

Are employee health plans provided? Y / N

Any 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

Any Claims in the past 3 Years? Y / N

Is your current Work Comp policy through a Payroll Company? Y / N

If you have any additional practice locations, please list them below: