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Workers' Comp Questionnaire

Business Name: _____

Address: _____

Entity Type (circle one): **Individual** **Corporation** **Partnership**

FEIN: _____ **Expiration date of current policy:** _____

Years in business: _____ **License No:** _____

List all officers holding 10% or more of stock and their titles:

Class Codes:

Payroll:

1. _____

2. _____

3. _____

4. _____

Part time employees _____

Full time employees _____

Does employer offer health benefits? _____ **What portion do you pay?** _____

Who is your provider? _____

Paid Sick, Vacation, Retirement Plans? _____ **% Paid** _____

Details of claims over \$25K: _____

Signature: _____

Date: _____

All fields required in order to obtain a quote.