Workers' Compensation Worksheet (Other)

Effective Date:

Named Insured: _____

Mailing Address: _____

Location of Bldg: _____

_____ **Zip Code** _____ **County** _____

If more than 1 location, please attach a list of all locations to be covered.

Nature / Type of Business: _____

Tax ID Number: _____

List Additional Named Insured's to be included, their tax id # & ownership % on separate page.

Type of Entity: ☐ **Corporation** ☐ **LLC** ☐ **Subchapter "S" Corp**
☐ **Partnership** ☐ **Individual** ☐ **Other** _____

Payroll Information

Class Code	Category	# Full Time Empl	# Part Time Empl	Annual Payroll
8810	Clerical – NOC			$
8742	Salespersons			$
7380	Drivers - NOC			$
				$
				$
				$

Ownership Info

Name	Title	% Owned	Duties	Est. Payroll	Include/Exclude

If you are anything other than a Corporation, do you want to be EXCLUDED from the policy?
☐ **Yes** ☐ **No** **If NO, you must include your payroll amount in above figures.**

Do you currently have WC Coverage? ☐ **Yes** ☐ **No** **If YES, please forward copy of Dec page.**

If YES, have you provided 5 yrs of Loss Runs?

Do you obtain Certificates of Insurance from all Subcontractors? ☐ **Yes** ☐ **No**

Contact Info

Name: _____ **Phone:** (____)_____
Email: _____ **Fax:** (____)_____

Ronald Diskin Associates Corp., PO Box 440, East Hanover, NJ 07936
(973) 599-9600 / (973) 599-9606 Fax / (201) 213-6590 Cell