Specialty Contractors Insurance Services, Inc.

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Workers' Compensation

Effective Date: _____

Business Name:_____

Sole Owner____ Partnership____ Corporation_____ LLC _____

Physical Address: _____

Mailing Address:_____

Phone: _____ Fax: _____ Email:_____

FEIN or SS #_____ Contractor's License #_____
Owner or Officer Names:_____

List all officers holding 10% or more of stock and their titles: (circle one)
_____ Included / Excluded
_____ Included / Excluded
_____ Included / Excluded

Business Description:
_____
_____

Subcontractors Used: Yes___ No____ Percentage of Work sub-contracted out: _____
If yes, for what purpose? _____

Class Code	Description	Projected Payroll	# of Full Time Employees	# of Part Time Employees

Do you have current insurance? Yes____ No ____
If yes, who is the carrier? _____

Indicate zero claims in last 5 years below, or provide loss runs (advise if you would like instructions on how to order):
_____
_____