

Western Benefit Solutions

WORKERS COMPENSATION SURVEY

Per your request, please fill out below, or if wish we would be more than happy to come out to fill out the survey with you.

COMPANY NAME _____ Phone _____
 Address: _____

Contact name for inspection or Questions _____

Type of work performed, services provided, product manufactured and hours of operations _____

Any safety program in effect? If yes describe _____

When would you like your new policy to take effect? _____

Classification Code	# of Employees F ull <u>T</u> ime or P art <u>T</u> ime	Payroll

If corporation please list

Name	Title (included or excluded)	Payroll

Your current carrier _____ (so we don't quote same rates)

Experience Mods? _____ Tax ID # _____

Number of losses in last 3 years _____ # of years in business _____

Group Medical Insurance Employer pays _____ or more for ALL employees Current Carrier _____

Benefits provided only to management and supervisors No employer provided Health Care 401K/IRA/SEP

THANK YOU FOR THE OPPORTUNITY TO QUOTE YOUR INSURANCE!!

675 N. First St. Ste #150 San Jose, CA 95112 Direct (408) 278-8355, Fax (408) 521-3348