QUOTE REQUEST FORM
WORKERS' COMPENSATION

Legal Business Name: _____

Property Address: _____

Mailing Address: _____

Contact Phone: _____ E-mail: _____

Legal Entity: Individual ___ Corporation ___ Partnership ___ LLC ___ Other ___

Years of experience: _____ Years in business: _____ Is this a new venture? _____

Federal ID Number: _____

Requested Effective Date: _____

Are Officers/Owners to be Included or Excluded? _____

How many total employees do you have? _____ How many are part-time? _____

What is gross salary for **all** employees, excluding officers? _____

What is gross salary for Officers? _____

List names of all officers/ owners: _____

Name of Current Insurance Carrier: _____

Any claims? _____ *If so, please fax a copy of your loss report to 850-681-9782.*

Are health benefits provided? _____

Out of state travel? _____ Do employees dispose of hazardous material? _____

Please complete this form and submit by email to insurance@fdaservices.com.
Once we receive your request, an agent will reach out to you for any further information required.

Please call us at 800.877.7597 if you have any questions or need help completing this form.

The data collected on this form is for information purposes only in order for us to provide you a quote. No coverage is in force until a policy is issued.