



WORKERS' COMPENSATION BALLPARK QUOTE FORM



Your Name _____ FEIN/SS# _____
 Individual Corporation LLC Partnership "S" Corp Other _____

Practice Name _____
 Mailing Address _____
 City _____ County _____ State _____ Zip _____

Primary Practice Location Number of total locations of practice _____

Street Address _____
 City _____ County _____ State _____ Zip _____

Hours Practiced Per Week _____ Years in Practice (with Worker's Comp coverage) _____

Web Address: www. _____
 Phone _____ Fax _____ Email Address _____

Best Way to Contact Phone Email Fax
 Contact Person _____ Now Closer to My Expiration Date

Attach a copy of your last declarations page(s):
 Current Carrier _____ Current Premium _____
 Current Limits _____ / _____ Current Deductible _____
 Current Expiration Date _____ Requested Effective Date _____

Number of employees. Do include ALL officers of a corporation in this count.

Name	Class Code	Name	Class Code	Name	Class Code
Total Number of Full-Time Employees		Total Number of Part-Time Employees		<input type="radio"/> Employees: Attach list of additional employee names.	

Gross Annual Staff Payroll	\$	Full Time Employees	#	Part-Time Employees	#
	\$	Myself			
GRAND TOTAL	\$	Exempt Me		Do Not Exempt Me	

Professional Services Plans
 3101 W Martin Luther King Jr. Blvd, Ste 400, Tampa, FL 33607
 Ph: (800) 467-8734 x 5150 Fax: (813) 222-4288