



Worker's Compensation Questionnaire

Name of Organization/Business _____

Mailing Address: _____

Contact Person: _____ Phone: _____

E-mail Address: _____ Fax: _____

Date of Incorporation: _____

* Federal ID is needed, or Declaration page with Federal ID in order to get a quotation.

<i>Class Code</i>	<i># Of Employees</i>	<i>Payroll</i>

Insurance Company: _____

Renewal Date: _____

Experience Modifier: _____

Federal ID #: _____

Any officers, partners, or relatives included or excluded:

Past Injuries:

Please attach 5 years of loss reports from each insurance company. (If available)

Services Provided:

Briefly describe the services provided by your organization:

Please return this by fax to (248) 373-5586, or by mail to:

Brownrigg Companies, LTD

2601 S. Lapeer Rd

Auburn Hills, MI 48326

(800) 397-5580

www.brownrigg.com

