Besnard & Associates Insurance
Workers' Compensation Program
Quote Sheet

Owner/Operator Name: _____

Business Entity Name(s): _____

Mailing Address: _____

Physical Address:
(if different than mailing) _____

Phone: **Fax:** _____

FEIN: **Email:** _____

Do you have a Safety Program? YES ❒ NO ❒

Check ONE: Sole Prop ❒ Corporation ❒ Partnership ❒ LLC ❒ Sub Chapter-S ❒ OTHER ❒ _____

How many stores do you own? _____

Code/Description:	State – (KS, MO, PA, etc.) Please include a separate sheet for each State:	**ANNUAL Payroll:**	**Est. Number of Employees (FT/PT):**
Restaurant , Crew, Managers & Maintenance			
Clerical Office & Administration			
Other – please describe			

NCCI Experience MOD Factor (leave blank if unknown): _____

Ownership Information

Name	**Title**	**Ownership %**	**Included / Excluded From Workers Comp**	**Est. Base Pay**

BESNARD & ASSOCIATES INSURANCE
www.BesnardWorkComp.com

web **FAX: (877) 644-3670 Questions? ☎ (877) 200-1718 💻 Rob.Barnes@BesnardInsurance.com**