

Workers' Compensation Restaurant Program 2009 Quote Sheet

Owner/Operator Name:	_____
Business Entity Name:	_____
Mailing Address:	_____
Physical Address: (if different than mailing)	_____
Phone/Fax:	_____
FEIN:	_____
Do you have a Safety Program? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Check ONE: Sole Prop <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> LLC <input type="checkbox"/> Sub Chapter-S <input type="checkbox"/> OTHER <input type="checkbox"/> _____	
Please attach these worksheets if they are available	
Current Experience MOD Factor:	<input style="width: 150px; height: 20px;" type="text"/>

Ownership Information

Name	Title	Ownership %	Duties	Included / Excluded	Payroll

Code/Description:	State – (FL, GA, AL, etc.) Please include a separate sheet for each:	ANNUAL Payrolls to use in Rating:	Indicate Number of Employees:
Restaurant , Crew, Managers & Maintenance			
Clerical Office & Administration			
Other – please describe			

Completed by: _____ Date: _____ Title: _____

IMPORTANT - PLEASE COMPLETE:

- ✓ attach a list of owned stores / locations to ensure your quote is issued correctly
- ✓ include at least three years of loss runs, currently valued
- ✓ sign and return this form with accompanying information to:

BESNARD & ASSOCIATES INSURANCE 16506 Pointe Village Drive, Suite 103 Lutz, FL 33558
OR FAX: (813) 926-1724 Questions? ☎ (877) 200-1718 / ✉ WC@BESNARDINSURANCE.COM