



Preferred Workers' Compensation Program Quick Quote Sheet

Business Entity Name:	_____
Owner/Operator Name: <small>If a franchisee</small>	_____
Mailing Address:	_____
Physical Address: <small>(if different than mailing)</small>	_____
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 the NCCI worksheet if available

NCCI Experience MOD Factor: _____

Non-Public Companies ONLY - Ownership Information

Name	Title	Ownership %	Duties	Included / Excluded	Payroll

- ✓ attach a list of work 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
 3000 Bayport Dr. Suite 400 Tampa, FL 33607
 OR FAX: (813) 287-1850 Questions? ☎ (877) 200-1718

