

# SKYLES INSURANCE AGENCY

PLEASE ANSWER THE FOLLOWING QUESTIONS FOR YOUR WORKER'S COMPENSATION QUOTE

1	CONTRACTORS LICENSE/APP NUMBER		FEIN/SSN		QUOTE NEEDED BY	
	BUSINESS NAME					
	OWNERS NAME		YEARS OF EXPERIENCE			
	ADDRESS (no PO BOX)					
	CITY, STATE, ZIP		COUNTY			
2	PHONE NUMBER	FAX NUMBER	EMAIL ADDRESS			
	PLEASE CONTACT ME BY _____ PHONE _____ FAX _____ EMAIL					
3	DESCRIBE IN DETAIL THE SCOPE OF YOUR COMPANY'S WORK/OPERATIONS, INCLUDING CLASS CODES					
4	DESCRIBE THE SCOPE OF YOUR EMPLOYEE'S WORK/DUTIES (PLEASE INCLUDE CLERICAL/OFFICE RELATED DUTIES IF ANY)		ESTIMATED ANNUAL PAY	Pay Rate (\$/hr)	# EMPLOYEES	
					FT	PT
	1					
	2					
	3					
	4					
5						
5	DO YOU HAVE A CURRENT WORKER'S COMP POLICY _____ YES _____ NO			EXP. DATE		
	WHAT IS YOUR WORKER'S COMPENSATION MOD FACTOR (if known)					
	DESCRIBE YOUR WORKER'S COMPENSATION LOSS HISTORY (if any)					
	HOW MANY YEARS HAVE YOU CARRIED WORKER'S COMPENSATION INSURANCE					
	DO YOU HAVE ANY WORK EXPOSURE OUTSIDE OF CA _____ YES _____ NO					

Please fax or mail this completed form back to us so we can get started on your quote.

You can also fill out this form online at [www.skylesinsurance.com](http://www.skylesinsurance.com)