



# Pizza Program Workers' Compensation Questionnaire



Company Name: \_\_\_\_\_ DBA: \_\_\_\_\_  
 Mailing Address: \_\_\_\_\_  
 Business Phone: \_\_\_\_\_ Business Fax: \_\_\_\_\_  
 Cell or Home Phone: \_\_\_\_\_ Email : \_\_\_\_\_  
 Address of All Restaurant Locations: **(Attach separate sheet if more than 2 locations or if additional space is necessary)**

Number of Years in Business: \_\_\_\_\_ If new, include resumé of previous experience.  
 Federal Employer ID #: \_\_\_\_\_ State Employer ID #: \_\_\_\_\_  
 Partnership Sole Proprietor Corporation LLC Other, please describe: \_\_\_\_\_

### PAYROLL INFORMATION

<u>Classification</u>	<u>Estimated Annual Payroll</u>	<u>No. of Full-Time Employees</u>	<u>No. of Part-Time Employees</u>
Restaurant	_____	_____	_____
Delivery	_____	_____	_____
Clerical (if any)	_____	_____	_____

(Full-Time = 30 or more hours per week)

Hours of Operation: \_\_\_\_\_ Hours of Delivery: \_\_\_\_\_

Are mopeds or bicycles used for delivery? Yes No

Do you have children living at home who work in the store? Yes No

If yes, please list the children's names & ages: \_\_\_\_\_

Is medical coverage offered to eligible employees? Yes No

If yes, do you pay at least 50% of the premium? Yes No

If "Partnership" or "LLC", list name, title and percentage of ownership for all partners and members. Total percentage of ownership must equal 100%. Only Partners that have ownership or Managing Members of an LLC can be excluded.

Name	Title	Ownership %	Annual Salary	Coverage Included or Excluded
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

If "Corporation", list name, title and percentage of ownership for all officers. Total percentage of ownership must equal 100%. Corporations must have a President, Secretary and Treasurer. Only those that have ownership and title can be excluded.

Name	Title	Ownership %	Annual Salary	Coverage Included or Excluded
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**Any change of the entity, such as incorporation or creation of a partnership should be reported to us immediately. These changes could affect your premium.**

**LOSS INFORMATION REQUIRED - Please attach current loss runs for last five years.**

Current Insurance Carrier: \_\_\_\_\_ Effective date of coverage: \_\_\_\_\_

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_