MDIS Missouri Dental INSURANCE SERVICES

MDIS4DDS.com | T 573-636-8752 | F 573-634-5770

WORKER'S COMPENSATION QUOTE FORM

Location Information

Entity Name: _____ Tax I.D.: _____

Office Address: _____ City: _____

State: _____ Zip Code: _____ Entity Type (Sole Prop, LLC, etc.): _____

Ph: _____ Fax: _____

# of Years in Business: _____ Email: _____

Payroll Information

Payroll: $_____ (Total annual payroll for full & part-time staff, not including owner)

Of Full-Time Staff _____

Of Part-Time Staff _____

Payroll: $_____ ($52,900 for Sole Proprietor/Partner, Corporate Officer or LLC member)

Total: $ _____ (Combine both staff and owner payrolls)

Policy Limits

Limits Desired: ◯ $100,000/500,000/100,000 ◯ $500,000/500,000/500,000

◯ $1 Million / 1 Million / 1 Million *Recommended

Underwriting Questions

Please explain all "Yes" Responses: (on a separate piece of paper)	Yes	No
Is the applicant involved in any other type of business?	◯	◯
Are Sub-contractors used?	◯	◯
Do you lease any employees to or from other employers?	◯	◯

Please explain all "No" Responses: (on a separate piece of paper)	Yes	No
Are workstations ergonomically designed?	◯	◯
Do all employees use personal protective equipment As required by OSHA or other state regulations?	◯	◯

Have you had any Worker's Compensation Claims in the last 3 years?

◯ No previous claims history ◯ Yes If yes, please provide the following information on a separate piece of paper: date of loss, description, and amount paid.

This form is to gather information for quoting coverage, this is NOT a confirmation of coverage.
A copy of our **"Notice of Privacy Practice & Policies"** is available upon request from the MDIS office or at the MDIS website, www.MDIS4DDS.com.