



Associations Insurance Agency, Inc.

An ASSOCIA[®] Company

Worker Compensation Questionnaire

Full Name of Association		
Physical Address (include Zip and county)		
Name and Phone Number of Association Contact		
Federal Employer ID Number/Tax ID Number		
Name of Management Office		
Estimated Annual Payroll by Class		
Description of Duties	Annual Payroll	Number of Employees
Loss History		
Please provide any loss history that is available and prior carrier information		

Signature

Title

Please fax this form to Elizabeth Miller at 214/276-1667 or send to emiller@associationsinsuranceagency.com for a quote.