



**WORKERS COMPENSATION RISK QUALIFICATION FAX FORM**

TO: <b>Mid Atlantic Insurance Services</b>	TODAY'S DATE: _____	PROPOSED EFF DATE: _____
FAX: <b>804/377-1169</b>		
YOUR NAME: _____ EMAIL ADDRESS: _____		
AGENCY NAME: _____		
STREET ADDRESS: _____ CITY/STATE/ZIP: _____		
AGENCY PHONE #: _____ AGENCY FAX #: _____		

APPLICANT'S NAME: \_\_\_\_\_ BUSINESS PHONE #: \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_

CITY/STATE/ZIP: \_\_\_\_\_ COUNTY: \_\_\_\_\_ FED ID#: \_\_\_\_\_

DESCRIBE ALL OPERATIONS:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

YEARS IN BUSINESS: \_\_\_\_\_ YEARS AT THIS LOCATION: \_\_\_\_\_

CURRENT INSURANCE COMPANY NAME: \_\_\_\_\_ CURRENT PREMIUM: \_\_\_\_\_

COMPANY YOU WOULD LIKE QUOTED: \_\_\_\_\_

EXPERIENCE MOD FACTOR (IF ANY): \_\_\_\_\_

NUMBER OF LOSSES IN LAST 3 YEARS: \_\_\_\_\_ 3 YEAR AVG LOSS RATIO: \_\_\_\_\_

**EXPOSURES BY STATE**

<u>CLASSIFICATION</u>	<u>PAY ROLL</u>	<u>NUMBER OF EMPLOYEES</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(AGENTS- PLEASE DO NOT WRITE IN THE SPACE BELOW) <b>ALL WORKERS COMP APPS MUST BE SIGNED BY APPLICANT</b>	
___ PRELEMINARY QUOTE: _____	AGENT'S COMMISSION: _____
___ WE NEED THE FOLLOWING ADDITIONAL INFORMATION: _____	
___ SEND FULLY COMPLETED ACORD APPS ___ SEND HARD COPY LOSS RUNS	
___ INELIGIBLE	
COMMENTS: _____ _____	

**\*\*\*PLEASE DO NOT FAX APPLICATIONS WITH THIS FORM\*\*\***  
**PLEASE INCLUDE A COPY OF THE "APPROVED" FORM WITH YOUR SUBMISSION**  
**THANKS FOR LETTING US SERVE YOU!**