rev.	04/	09
IEV.	U 4 /	U9

BUSINESS NAME: PHONE: FAX: EMAIL: ADDRESS:	APPLICANT NAME:			DATE:			
ADDRESS: CITY: STATE: STATE	DUCINECC NAME.						
STATE TAX ID#: FEDERAL TAX ID#: CONTRACTORS LIC #: ENTITY IS: O INDIVIDUAL. O PARTNERSHIP O JOINT VENTURE O CORPORATION OTHER: EXPERIENCE MODIFICATION: IN BUSINESS SINCE: PROJECTED ANNUAL GROSS SALES: CLASSIFICATION & PAYROLL INFORMATION: CLASS CLASSIFICATION NUMBER OF ESTIMATED CODE: DESCRIPTION: EMPLOYEES: ANNUAL PAYROLL: WORKERS COMP POLICY PERIOD: FROM THROUGH NAME OF PRIOR INSURER: EXPIRING PREMIUM: EXPIRING PAYROLL:	PHONE:	FAX:		EMAIL	·:		
STATE TAX ID#: FEDERAL TAX ID#: CONTRACTORS LIC #: ENTITY IS: O INDIVIDUAL. O PARTNERSHIP O JOINT VENTURE O CORPORATION OTHER: EXPERIENCE MODIFICATION: IN BUSINESS SINCE: PROJECTED ANNUAL GROSS SALES: CLASSIFICATION & PAYROLL INFORMATION: CLASS CLASSIFICATION NUMBER OF ESTIMATED CODE: DESCRIPTION: EMPLOYEES: ANNUAL PAYROLL: WORKERS COMP POLICY PERIOD: FROM THROUGH NAME OF PRIOR INSURER: EXPIRING PREMIUM: EXPIRING PAYROLL:	ADDRESS:						
ENTITY IS: O INDIVIDUAL O PARTNERSHIP O JOINT VENTURE O CORPORATION OTHER:							
EXPERIENCE MODIFICATION: IN BUSINESS SINCE: PROJECTED ANNUAL GROSS SALES:	STATE TAX ID#:	FEDERAL TA	AX ID#:	CONTRACTORS LIC #:			
PROJECTED ANNUAL GROSS SALES: CLASSIFICATION & PAYROLL INFORMATION: CLASS CLASSIFICATION NUMBER OF ESTIMATED EMPLOYEES: ANNUAL PAYROLL: WORKERS COMP POLICY PERIOD: FROM THROUGH NAME OF PRIOR INSURER: IS THERE A FORMAL SAFETY PROGRAM?: YES NO EXPIRING PREMIUM: WORKERS COMP LOSSES?: YES NO NAME OF OFFICERS / OWNERS TO BE INCLUDED OR EXCLUDED:	ENTITY IS: O INDIVIDUAL	PARTNERSHIP O	JOINT VENTU	RE O CO	RPORATION (OTHER:	
CLASS CLASSIFICATION NUMBER OF ESTIMATED CODE: DESCRIPTION: EMPLOYEES: ANNUAL PAYROLL: WORKERS COMP POLICY PERIOD: FROM THROUGH NAME OF PRIOR INSURER: EXPIRING PREMIUM: IS THERE A FORMAL SAFETY PROGRAM?: YES NO EXPIRING PAYROLL: ANY WORKERS COMP LOSSES?: YES NO IF YES, PLEASE PROVIDE DETAILS BELOW AND NAME OF OFFICERS / OWNERS TO BE INCLUDED OR EXCLUDED:	EXPERIENCE MODIFICA	ATION:	IN BUS	INESS SIN	CE:		
CLASS CLASSIFICATION DESCRIPTION: WORKERS COMP POLICY PERIOD: FROM THROUGH NAME OF PRIOR INSURER: IS THERE A FORMAL SAFETY PROGRAM?: ANY WORKERS COMP LOSSES?: OF YES, PLEASE PROVIDE DETAILS BELOW AND NAME OF OFFICERS / OWNERS TO BE INCLUDED OR EXCLUDED: -IF INCLUDED, INDICATE CLASS CODE AND SALARY: EMPLOYER PROVIDES HEALTH INSURANCE FOR AT LEAST 50% OF EMPLOYEES?: WORKERS COMP LOSSES?: OF YES, NAME THE HEALTH INSURANCE FOR AT LEAST 50% OF EMPLOYEES?: NO -IF YES, NAME THE HEALTH INSURANCE FOR AT LEAST 50% OF EMPLOYEES?: OFFICERS / OWNERS TO BE INCLUDED OR EXCLUDED: OFFICERS / OWNERS / OWN	PROJECTED ANNUAL G	ROSS SALES:					
WORKERS COMP POLICY PERIOD: FROM THROUGH NAME OF PRIOR INSURER: EXPIRING PREMIUM: IS THERE A FORMAL SAFETY PROGRAM?:	CLASSIFICATION & PAY	ROLL INFORMATION	N:				
WORKERS COMP POLICY PERIOD: FROM THROUGH NAME OF PRIOR INSURER: EXPIRING PREMIUM: IS THERE A FORMAL SAFETY PROGRAM?:	CLASS CODE:	CLASSIFICATION DESCRIPTION:	1	NUM EMP	IBER OF LOYEES:	ESTIMATED ANNUAL PAYROLL:	
WORKERS COMP POLICY PERIOD: FROM THROUGH NAME OF PRIOR INSURER: EXPIRING PREMIUM: IS THERE A FORMAL SAFETY PROGRAM?: YES NO EXPIRING PAYROLL: ANY WORKERS COMP LOSSES?: YES NO (IF YES, PLEASE PROVIDE DETAILS BELOW AND NO (IF YES, PLEASE PROVIDE DETAILS BELOW AND NO (IF YES, PLEASE PROVIDES TO BE INCLUDED OR EXCLUDED:IF INCLUDED, INDICATE CLASS CODE AND SALARY: EMPLOYER PROVIDES HEALTH INSURANCE FOR AT LEAST 50% OF EMPLOYEES?: YES NO -IF YES, NAME THE HEALTH INSURER: NO							
IS THERE A FORMAL SAFETY PROGRAM?:				THROU	JGH		
ANY WORKERS COMP LOSSES?:	NAME OF PRIOR INSUR	ER:			EXPIRING	PREMIUM:	
-IF INCLUDED, INDICATE CLASS CODE AND SALARY: EMPLOYER PROVIDES HEALTH INSURANCE FOR AT LEAST 50% OF EMPLOYEES?: YES NO -IF YES, NAME THE HEALTH INSURER:	ANY WORKERS COMP L	OSSES?:			EXPIRING	PAYROLL:	
-IF INCLUDED, INDICATE CLASS CODE AND SALARY: EMPLOYER PROVIDES HEALTH INSURANCE FOR AT LEAST 50% OF EMPLOYEES?: YES NO -IF YES, NAME THE HEALTH INSURER:							
EMPLOYER PROVIDES HEALTH INSURANCE FOR AT LEAST 50% OF EMPLOYEES?: VES NO -IF YES, NAME THE HEALTH INSURER:							
APPLICANT / PRODUCER SIGNATURE: DATE:	EMPLOYER PROVIDES I	HEALTH INSURANCE	FOR AT LE	AST 50% (OF EMPLOYI		
	APPLICANT / PRODUCER	SIGNATURE:				DATE:	

P.O. BOX 6480, VACAVILLE, CA 95696 PHONE: 707.469.6776 FAX: 707.469.8072 WWW.ECLIPSEINSURANCE.COM LIC.# 0D60747