Reset Form

ECLIPSE WORKERS COMPENSATION SMART APP

Print Form

Email F

APPLICANT NAME: _____ **DATE:** _____

BUSINESS NAME: _____

PHONE: _____ **FAX:** _____ **EMAIL:** _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

STATE TAX ID#: _____ **FEDERAL TAX ID#:** _____ **CONTRACTORS LIC #:** _____

ENTITY IS: ○ **INDIVIDUAL** ○ **PARTNERSHIP** ○ **JOINT VENTURE** ○ **CORPORATION** ○ **OTHER:** _____

EXPERIENCE MODIFICATION: _____ **IN BUSINESS SINCE:** _____

PROJECTED ANNUAL GROSS SALES: _____

CLASSIFICATION & PAYROLL INFORMATION:

CLASS CODE:	CLASSIFICATION DESCRIPTION:	NUMBER OF EMPLOYEES:	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

_____

_____

_____

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?: ☐ **YES** ☐ **NO**

-IF YES, NAME THE HEALTH INSURER: _____

APPLICANT / PRODUCER SIGNATURE: _____ DATE: _____