



Workers Compensation Quoting & Application Form

General Information

Practice name: _____

Address: _____

County: _____ Contact name: _____

Phone number: _____ Fax number: _____

How long has the practice been open? _____ Proposed effective date: _____

Federal ID number (FEIN): _____ Number of years in business: _____

Current carrier: _____ Annual sales: _____

Organization structure: Sole Proprietor Partnership Corporation Limited Liability Corp.

List any other business locations: _____

Any out of state exposure? Yes No

NCCI # from previous Workers Compensation Policy (if known): _____

How did you hear about MSVIA? _____

Workers Compensation Liability Limit Choices

Please note: If you are planning on purchasing an umbrella policy, you must have workers compensation limits of at least \$500,000/ \$500,000/ \$500,000.

\$100,000 each accident/ \$500,000 disease – Policy limit/ \$100,000 disease – Each employee

\$500,000 each accident/ \$500,000 disease – Policy limit/ \$500,000 disease – Each employee

\$1,000,000 each accident/ \$1,000,000 disease – Policy limit/ \$1,000,000 disease – Each employee

Other insurance policies currently in force:

Type of insurance	Company name	Policy #	Expiration date	Liability limit
Commercial Umbrella policy				
General liability				
Business Auto policy				

Payroll Information for Physicians

Name	Title (i.e.: Sole proprietor, Partner, Executive officer, Managing member of limited liability corp. or Employed physician)	Percent of Owner-ship	Include / Exclude coverage?	Salary

Payroll Information for Non-Physician Employees

Number of Employees		Total annual payroll for all office staff and medical personnel
Full Time	Part Time	

Note: If coverage is rejected by the officers of a corporation, or by managing members of a limited liability corporation, a *Rejection of Coverage* form must be signed and submitted to the State Compensation Board.

Please send me a Workers Compensation *Rejection of Coverage* form Yes No

Note: Workers Compensation policies are “auditable” policies. Insurance companies have the option of performing annual payroll audits to determine if payrolls have increased or decreased. Future policy premiums could either increase or decrease, depending on the total payroll in a given year.

General Questions

Do you have any additional locations? Yes No

If yes, please provide address: _____

Are any of your locations used as a business office only (no patients)? Yes No

Has coverage for workers compensation been previously declined? Yes No

Are you engaged in any other type of business? Yes No

Is there a written employee safety program in place? Yes No

Do any employees travel outside of the country? Yes No

General Questions (continued)

- | | | |
|--|-----|----|
| Are employee health plans provided? | Yes | No |
| Are physicals required for employees after an offer of employment is made? | Yes | No |
| What is the annual employee turnover? _____% | | |
| Do you have any physicians working with you as independent contractors? | Yes | No |
| Do you use any subcontractors, of any kind? | Yes | No |
| Do you employ a cleaning or maintenance staff? | Yes | No |
| Do you have any temporary employees, or are temporary workers provided from any "temp" type organization? | Yes | No |
| Do you lease any employees to or from any other employers? | Yes | No |
| Is there any volunteer or donated labor? | Yes | No |
| Are there any employees under 16 or over 60 years of age? | Yes | No |
| Are there any employees with physical handicaps? | Yes | No |
| Do you collect certificates of insurance from all workers (not employed by you) who perform work on your premises (i.e. painters, plumbers, etc.)? | Yes | No |
| Is ground transportation ever provided for 5 or more employees of the organization (in the same vehicle) at one time? | Yes | No |
| Do you hire, lease or own aircraft or watercraft for business use? | Yes | No |
| Do you sponsor any employee athletic teams? | Yes | No |
| Have you had any workers compensation claims within the past 5 years? | Yes | No |

If yes, please describe: _____

If you answered "Yes" to any of the questions above, please provide additional information: _____

Applicant signature: _____ Date: _____

NOTE: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing false information, or conceals for the purpose of misleading any fact material thereto, commits a fraudulent insurance act which is a crime.

Medical Society of Virginia Insurance Agency
2924 Emerywood Pkwy., Ste. 200 | Richmond, Virginia 23294
TF Phone: 877 | 226 - 9357 TF Fax: 800 | 842 - 0250