



HEFFERNAN INSURANCE BROKERS

A Member of the Heffernan Group

Workers' Compensation Questionnaire

Your Name: _____ Owner's Name: _____

Name of Company: _____

Address: _____ City, State Zip : _____

Phone Number: _____ Fax Number: _____

Email: _____ Website: _____

Date Company Established/#years in Business _____

Federal Employer I.D. #: _____

Owners, Officers, Directors or Partners, Included or Excluded:

Names & Titles: _____

Excluded or Included: _____ % of Ownership: _____

Do you provide Health insurance to your full time employees? _____

If yes, do you pay for 50% or more _____ Who is the provider _____

- Attach a copy of the Declaration & Payroll pages from your current policy **OR** provide the following information:

CLASSIFICATION	CLASS CODE	# of Emp. Pier Diem	# of Emp. Full Time	ESTIMATED ANNUAL PAYROLL
Public Health Nursing	8827 or 8835			\$
Homemaking Services	8827 or 8835			\$
Clerical	8810			\$
Hospitals/Nursing Homes	9043			\$

- **Please provide the most current Workers' Compensation claims for the past five years.**
- Please fax back to Tami Unsworth at 925-934-8278 or call with questions at 925-942-4619.

