REZA SHAH
FINANCIAL & INSURANCE SERVICES, INC

Workers Compensation Quote Form

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GENERAL INFORMATION

BUSINESS NAME:		DBA:		YEARS IN BUSINESS:
MAILLING ADDRESS:	CITY:	STATE:	ZIP:	DATE OF FIRST EMPLOYEE HIRED:
CONTACT:	TITLE:		FAX:	
PHONE:	CELL PHONE:		E-MAIL:	
EFFECTIVE/EXPIRATION DATES FROM: TO:	FED TAX ID#:		STATE ID#:	

TYPE OF BUSINESS: ☐ SOLE PROPRIETOR ☐ PARTNERSHIP ☐ CORPORATION ☐ LLC ☐ NON - PROFIT ☐ "S" CORP

DO YOU OFFER A GROUP HEALTH PLAN? ☐ YES ☐ NO	IF YES, WHAT COMPANY?
PRIMARY LOCATION ADDRESS:	SECONDARY LOCATION ADDRESS:

EMPLOYEES/OFFICERS INFORMATION: (PLEASE CATEGORIZE ALL EMPLOYEES)

CODE	EMPLOYEE CLASSIFICATION (EG. CLERICAL, MANAGER)	# OF FULL TIME EMPLOYEES:	# OF PART TIME EMPLOYEES:	TOTAL ANNUAL SALARY:

OFFICERS INFORMATION:

TITLE	NAME	STATUS	DOB	SOCIAL SECURITY	OWNERSHIP %	ANNUAL SALARY
PRESIDENT		INC / EXC				
VICE - PRESIDENT		INC / EXC				
SECRETARY		INC / EXC				
TREASURER		INC / EXC				

PRIOR CARRIER INFORMATION:

MONTH/YEAR	INSURANCE COMPANY	POLICY NUMBER	# OF CLAIMS

I'M ALSO INTERESTED IN (CHECK ANY/ALL THAT APPLY):

☐ SURETY BOND ☐ AUTOMOBILE INSURANCE ☐ GROUP/INDIVIDUAL MEDICAL ☐ ANNUITY SAVING PROGRAMS
☐ HOMEOWNER/FLOOD INSURANCE ☐ LONG TERM CARE INSURANCE ☐ GENERAL LIABILITY & PROPERTY ☐ WORKERS COMPENSATION
☐ PHYSICAL & SEXUAL ABUSE COVERAGE ☐ RETIREMENT PROGRAMS, 401 (K) ☐ DENTAL/VISON INSURANCE ☐ LIFE INSURANCE PROGRAMS

PLEASE FAX OR EMAIL THIS FORM TO REZA SHAH ALONG WITH YOUR LOSS RUN HISTORY FOR THE PAST 4 YEARS AND A COPY OF YOUR PREVIOUS POLICY.

This form and information is intended for a quote. It is not an insurance contract. Actual policy describes your coverage.
By submitting this form I certify that the above information is accurate and true.

SIGNATURE _____ DATE