



WORKERS COMPENSATION APPLICATION

COSSIO INSURANCE AGENCY

Directions: Please complete each item by clicking above the line and typing in the correct information. Use your mouse and click the checkboxes to check and uncheck the selection.

Company Name: _____ Start Date: _____

Tax Id No.: _____

Contact Name: _____ Title: _____

Work Phone: _____ Fax: _____

Home Phone: _____ E-mail: _____

Mailing Address: _____

City: _____ State: _____ Zip code: _____

Premises Address: _____

City: _____ State: _____ Zip code: _____

Nature of business/detailed description of operations: _____

Year the business started: _____

Prior Insurance Carrier: _____

Policy Number: _____ Effective dates (M/Y): _____

Is company canceling coverage? yes no

Why?: _____

Total premium: _____ Any claims in the last five years? yes no

Employee payroll figures:

	No. of Full Time	No. of Part Time	Annual Payroll Renumeration
Secretaries	_____	_____	_____
Retail Employees	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Owners Included/Excluded: Included Excluded
Name: _____ Title: _____

Relationship: _____

Name: _____ Title: _____

Relationship: _____

I _____ (name) certify that the above given information is true and correct.

Signature

Date

Once you have filled out the form with the correct information please click on the submit button below to save this filled out document. Attach this saved document to an e-mail and send it to the e-mail addresses below.