



Name of Organization: _____ Requested effective date: ____/____/____

Mailing Address: _____
(street) (county) (city) (state) (zip code)

Physical Addresses: *(Attach extra sheet, if necessary)*

(street) (county) (city) (state) (zip code)

(street) (county) (city) (state) (zip code)

Phone: _____ Fax: _____ FEIN No.: _____

Email address: _____ Web site address: _____

Administrator or CEO/Insurance Contact Person: _____

Years in Business: _____ Annual Revenue: _____

Nature of Business: _____

Employee Classification	Number of Employees	Estimated Annual Payroll
Clerical		
Outside Sales / Marketing		
Supervisory / Intake Only RN		
Home Health / Field RN		
Nursing – ALF		
Domestic Aides		
Hospital Staffing		
Physician Offices		

(Other Classifications? Please Attach Extra Sheet.)

Names of Partners/Officers to be Included or Excluded from Coverage:

Name	Date of Birth	Title	Ownership %	Inc/Exc
1.				
2.				
3.				

Do You?

- Have employees who regularly travel out of the state (as part of their job)? Yes No
- Sponsor any athletic teams? Yes No
- Have any labor interchange with any other subsidiary or affiliated company? Yes No
- Have any leased employees or volunteers? Yes No
- Have any 1099 or independent contractor labor relationships (PT's / OT's / MSW's)? Yes No

Please attach:

- Estimated Annual Revenues
- A List of Employees
- Three Years Loss History, If Applicable