COMMERCIAL APPLICATION
Worker's Compensation

Effective Date:	
Insured name:	
DBA:	
Legal entity (corporation, sole proprietor, etc.):	
FEIN/SSN:	
Phone number:	
Fax number:	
Cellular number:	
Street address:	
City, State, Zip Code:	
Years in Business:	
Number of employees:	
Prior Insurance? (incl. carrier name, premium amount, and expiration date)	
Prior Losses? (if yes, provide loss runs)	
Nature of Business:	
Class code:	
Annual payroll per class code:	
Class code:	
Annual payroll per class code:	
Class code:	
Annual payroll per class code:	
Experience Mod:	
Producer/Agency:	

ADDITIONAL NOTES:

Fax your request to 760-744-2680 or email to steve@gibbsinsurance.com

APPLICATION SUBMISSION DOES NOT BIND COVERAGE