FIRST INDEMNITY
INSURANCE GROUP

Clear Form

Application for: Lawyers Workers Compensation (Page 1 of 2)

1. Requested Effective Date: _____ (mm/dd/yyyy) 2. Name of Present Carrier: _____

3. Applicant Information:

Name: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

4. Years in Business: _____ Years 5. Federal Employer ID Number: _____

6. Estimated Annual Payroll: $_____

7. Locations:

First Location:

Street: _____

City: _____ County: _____ State: _____ Zip Code: _____

Categories, Duties, Classifications: _____

No. of Employees: _____ Estimated Annual Remuneration: _____

Second Location (if applicable):

Street: _____

City: _____ County: _____ State: _____ Zip Code: _____

Categories, Duties, Classifications: _____

No. of Employees: _____ Estimated Annual Remuneration: _____

Third Location (if applicable):

Street: _____

City: _____ County: _____ State: _____ Zip Code: _____

Categories, Duties, Classifications: _____

No. of Employees: _____ Estimated Annual Remuneration: _____

8. Does the Insured have an Ownership Interest in any other business? ☐ Yes ☐ No

If Yes, please answer the following:

Business Name: _____

Street: _____

City: _____ State: _____ Zip Code: _____

Relationship with Insured: _____ Ownership: _____ %

Describe Business Operations: _____

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9. Does the Insured lease Employees from another Organization? ☐ Yes ☐ No

If Yes, please answer the following:

Number of Leased Employees: _____

Is Workers' Comp Coverage provided by the Leasing Organization? ☐ Yes ☐ No

Are Certificates of Workers' Comp Insurance obtained? ☐ N/A ☐ Yes ☐ No

10. Do any Employees travel outside the country? ☐ Yes ☐ No

11. Does the Insured have any Volunteer Labor? ☐ Yes ☐ No

If Yes, please answer the following:

Number of Volunteers: _____

Please Describe the scope of the duties of any Volunteers: _____

_____

_____

_____

_____

12. Are Workstations Ergonomically designed at all Locations? ☐ Yes ☐ No

If No, please explain: _____

_____

_____

13. Are all Employees provided with training/education on Ergonomic issues? ☐ Yes ☐ No

If No, please explain: _____

_____

_____

_____ _____

Insured's Signature Date

Save Form Print Form Submit Form