

The Clements Agency, LLC

14358 N Frank Lloyd Blvd Scottsdale, Suite 11, AZ 85260

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APPLICATION FOR WORKERS COMPENSATION

Owner/Operator Name: _____
Corporation ___ Partnership ___ Proprietorship ___ Years in Business _____

Legal Name: _____

Mailing Address: _____
Street City State Zip

Contact Person: _____ Telephone: _____ Fax: _____

Email Address: _____

Federal Employer Identification No.: _____ State Unemployment No.: _____

National Store No. **Store Address** (Additional Stores Please Attach a Separate Sheet)

Current Insurance Carrier: _____ Expiration Date: _____
Employers Liability Limits: \$ _____ \$ _____ \$ _____

Experience Modification: Current Expiring Year _____ Next Year _____

Annual Estimated Payroll by Classification: (if payrolls are in more than one state, list totals by state)

	Average	Number of Employees	
	Hourly Wage	Full-time	Part-time
8810 (Clerical)	\$ _____	_____/____	_____/____
9083 (Store)	\$ _____	_____/____	_____/____
8742 (Officers)	\$ _____	(Officers to be included? Yes ___ No ___)	

Please list name of officers, partners, date of birth, title, duties, % of ownership and exclude/include remuneration on separate sheet.

- ❖ Have you been cancelled or non-renewed within the last three years? Yes ___ No ___
- ❖ Do you own, operate or lease any aircraft? Yes ___ No ___
- ❖ Is there any volunteer or donated labor? Yes ___ No ___
- ❖ Do you lease employees to or from other employers? Yes ___ No ___
- ❖ Do you contribute to a medical plan for employees: Yes ___ No ___

Signature of Owner

Date

Please be sure to provide the following documentation:

- 1) 3 YEARS RECENTLY ISSUED LOSS RUNS and;**
- 2) Current year and next year's Experience Modification (EMOD) worksheets**