WORKERS' COMPENSATION
Subscriber Profile

PEO Name:_____ Date _____

	Proposed Effective Date:
Subscriber Data	Federal Tax ID:
Name:	SUI Rate
dba:	NCCI ID:
Address	Years in Business:
City, State, Zip:	Phone #:
Key Contact:	Fax # :
Owner:	
D.O.B.	
S.S. #	
% of Ownership	

(Please attach separate listing of all additional owners)

Type of Business

☐ Sole Proprietor ☐ Partnership ☐ Non- Profit ☐ Corporation ☐ LLC ☐ LLP ☐ PC

Description of Operation: (SIC Code)

Workers' Compensation History (Attach current loss runs and explanations of all claims over $15,000)

Year	Carrier	Policy #	Premium	Mod	# of Claims	Paid Losses	O/S Reserves

Employee Information (A separate payroll run may be provided. Provide complete information for each location)

NCCI Class Code	Rate	# of EEs	Duties	Annual Payroll