|  |  |
| --- | --- |
| Application for group Health-dentalLife-business & workcomp insurance[www.pnainsurance.com](http://www.pnainsurance.com),www.Smartlifepolicy.comTel-619-281-6666, Fax-619-281-6080, info@pnainsurance.com | C:\Users\PNA 3\Desktop\DTL\Misc\pna-logo (2).JPG |

|  |
| --- |
| 1.company name:  |
| Last Name |  | First |  | M.I. | Date |  |
| Street Address |  | Unit # |  |
| City |  | State |  | ZIP |  |
| Phone |  | Email |  |
| Web: |  | Fax |  | Tax ID |  |
| Business Type |  |
| Are you the Owner/President/CEO/CFO | YES [ ]  | NO [ ]  | Do you apply for Business & Work Comp Ins | YES [ ]  | NO [ ]  |
| New business? | YES [ ]  | NO [ ]  | If yes, year of experience |  If No, How many years at this location:  |
| Apply Group Health Insurance for all ? | YES [ ]  | NO [ ]  | If No, explain |  |
|  |
| 2. Census for group health-dental & Life ins.for your company. How many employees? |
| NAME |  | M F | Home Zip code Part Time Full Time  |
| DOB |  |  |  | Spouse OR Dep. | YES [ ]  | NO [ ]  | If Yes |  How many child/children  |
| Spouse | Name | DOB |  Age(s) of Children / / / |
| Pay Stub |  |  |  | Life Insurance | YES [ ]  | NO [ ]  | If yes | Face Amount $  |
| 2nd EY |  | M F | Home Zip code Part Time Full Time |
| DOB |  |  |  | Spouse Or Dep. | YES [ ]  | NO [ ]  | If Yes |  How many child/children |
| Remark: Please use your additional sheet for more Employees. Thank you. |
| 3. Information for yours business and or worker’s compensation insurance quotation. |
| Do you have current insurance today Yes:\_ No:\_ If yes, expiration date: |
| If No | Age of the building?  | Construction Type |  |
| Alarm  | If yes, Name of Company: | Roof Type |  |
| Total Area |  Customers Area :  |
| How many Employees |  | Payroll $ |  |
| Current Bus Ins. Comp. |  | Policy | # |
| Est. Income |   |
| Any Claim? |   | Pending? |  |
| Remark |  |  |  |
|  |  |

|  |
| --- |
| 4.worker’s compensation information  |
| Current Company |  | Phone |  |
| Address |  | Policy # |  |
| Renewal Date |  | Current Premium | $ | Renewal Premium | $ |
| Current payroll $ |  |
| Policy Since: |  | To |  | Any Claim? | If yes, Still Pending? Total Claim: |
| Can we be yours Broker of record for Insurance Company? | YES [ ]  | NO [ ]  |  |
| State Fund Company |  | Policy |  |
| Address |  | Expiration |  |
| Renewal Date |  | Current Premium | $ | Renewal Premium | $ |
| Any Claim?  | If yes, Sill Pending Total Claim: $ |
| Policy Since |  | To |  | Remark |  |
| Current Worker Compensation Ins. Comp.? If No | YES [ ]  | NO [ ]  |  |
| How many Employees |  | Total Payroll |  |
| How many Full time |  | How many Part time |  |
| Owner Included |  | Executive | $ | Exe. Members | $ |
| Executive & Exe Members Ins? |  |
| Req. Eff. | Date: |  |  |  |  |
| Do you need the insurance binder day? | YES [ ]  | NO [ ]  |  |
|  |
| remark |
|  |
| Disclaimer and Signature |
| I certify that my answers are true and complete to the best of my knowledge.  |
| Name & Signature |  | Date |  |

 Additional Sheet for more employees and or comments.