Optometric Protector Plan®
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WORKERS' COMPENSATION QUESTIONNAIRE

Requested Effective Date: _____

Legal Business Name: _____

Property Address: _____

Mailing Address: _____

Contact Phone: _____ Email: _____

Legal Entity: ☐ Individual ☐ Corporation ☐ Partnership ☐ LLC ☐ Other

Years of Experience: _____ Years in Business: _____ Is this a new venture? _____

Amount of your gross sales: _____

Location(s): 1. _____

2. _____

3. _____

What is your Federal Tax Id #: _____ How many total employees do you have? _____ How many are part-time? _____

What is the gross salary for all employees, excluding Officers: _____ What is the gross salary for Officers? _____

Are Officers/Owners to be included or excluded? _____ List the names of all Officers/Owners: _____

Name of current insurance Carrier: _____ Any claims? **If so, please attach a copy of the loss runs.** _____

Have you been cancelled or nonrenwed? If so, please provide an explanation. : _____

Are health benefits provided? _____ Out of state travel: _____ Do employees dispose of hazardous materials? _____

Salary for those doing grinding of lenses: _____ All other employees: _____

LIMITS: ☐ $100,000/$500,000/$100,000 ☐ $500,000/$500,000/$500,000 ☐ $1,000,000/$1,000,000/$1,000,000

Signature: _____ Date: _____