



FAX IT BACK ⇨ **888-PLIT-FAX** (754-8329)

Please complete and fax back for your free quote.

Questions? Please call 800-228-7548.

Workers' Compensation Application

General Information

Practice Owner: _____ Practice Name _____

Practice Contact Name: _____ Title: _____

Practice Address: _____ (city/state/zip) _____

Mailing Address: _____ (city/state/zip) _____

Phone: _____ Fax: _____

E-mail address: _____

Legal Structure: Sole Proprietor Partnership Corporation Limited Liability Company Other: _____

Practice Type: Small Animal Exclusive Predominantly Equine Mixed *mostly small animal* Mixed *mostly large animal*

Average weight of animals? _____ Years in business: _____

List **all** owners and officers of the practice and indicate if included or excluded (attach an additional page if necessary):

_____ Include Exclude ♦ Estimated Annual Payroll _____

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Do you have other locations? Yes No

Location Address: _____ (city/state/zip) _____

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Employee Information

Type of Employee	Class Code	Number of Employees Full/Part Time	Estimated Annual Payroll
Employed Veterinarians and Assistants (class code includes Receptionists)	8831		
Executive Officers, Partners, Proprietors, and Owners (only if included in coverage)	8831		
Clerical Duties Only (No Animal Contact)	8810		

Employee Information — continued

Average hourly wage of your employees? _____ Number of volunteers? _____

What safety programs do you have in place? _____

Federal Tax ID# _____ What is your experience modification factor? _____ No experience modification factor

How many people regularly drive for this business (farm calls, errands, transportation) _____

Any under 21? Yes No If yes, please list:

Name: _____ D.O.B. _____ DL# _____ State: _____ Date Issued: _____

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Insurance Information

Has any insurer canceled or declined to renew your workers' compensation insurance during the past three years? Yes No

If yes, explain _____

When does your current insurance expire? _____ Current Insurer: _____ Premium: _____

Please list the previous three years insurance information:

Dates of Coverage: _____ Insurer: _____ Premium: _____

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Please describe all claims in the past three years and the approximate cost of each claim (attach an additional page if necessary):

Date: _____ Description: _____ Amount Paid: _____

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Additional PLIT-sponsored Products

Please contact me with more information on the following PLIT-sponsored products.

Practice Owners Package Employment Practices Liability Veterinary License Defense Professional Liability Flood

Signature

Bind coverage effective: _____ (Coverage cannot be backdated.)

X _____ Date: _____

Completion of this application does not commit either party. In the event of conflict, the conditions and terms of the policy prevail. This contains a brief description of coverage and does not include all the benefits and limitations found in the policy. Coverage is subject to the policy terms and exclusions. The AVMA PLIT is not an insurance company.

Trust Broker and Consultant since 1962: HUB International Midwest Limited ♦ HUB International Midwest Insurance Agency (CA)

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