



NAT'L PIZZA PROGRAM WORKERS' COMPENSATION QUESTIONNAIRE



Company Name: _____ DBA: _____
Mailing Address: _____
Business Phone: _____ Business Fax: _____
Cell or Home Phone: _____ Email: _____
Address of All Restaurant Locations: (Attach separate sheet if more than 2 locations or additional space necessary)

Number of Years In Business: _____ If new, include resume of previous experience.
Federal Employer ID #: _____ State Employer ID #: _____
Partnership [] Sole Proprietor [] Corporation [] LLC [] Other [] If "Other" please describe: _____

PAYROLL INFORMATION

Table with 4 columns: Classification, Estimated Annual Payroll, No. of Full Time Employees, No. of Part-Time Employees. Rows include Restaurant, Delivery, Clerical (If any).

(Full Time = 30 or more hours per week)
Hours of operation: _____ Hours of delivery: _____
Are Mopeds or Bicycles used for delivery? Yes [] No []
Do you have children living at home who work in the store? Yes [] No []
If "yes" please list children's names & ages: _____
Is Medical Coverage offered to eligible employees? Yes [] No []
If yes, do you pay at least 50% of the premium? Yes [] No []

If "Partnership" or "LLC", list name, title and percentage of ownership for all partners and members. Total percentage of ownership must equal 100%. Only Partners that have ownership or Managing Members of an LLC can be excluded.

Table with 5 columns: Name, Title, Ownership %, Annual Salary, Coverage Included or Excluded. Multiple rows for listing partners.

If "Corporation", list name, title and percentage of ownership for all officers. Total percentage of ownership must equal 100%. Corporations must have a President, Secretary and Treasurer. Only those that have ownership and title can be excluded.

Table with 5 columns: Name, Title, Ownership %, Annual Salary, Coverage Included or Excluded. Multiple rows for listing officers.

Any change of the entity, such as incorporation or creation of a partnership should be reported to us immediately. These changes could affect your premium.

LOSS INFORMATION REQUIRED Please attach current loss runs for last five years

Current Insurance Carrier _____ Effective date of coverage: _____

Signature of Applicant: _____ Date: _____