PROFESSIONAL SERVICES PLANS

WORKERS' COMPENSATION BALLPARK QUOTE FORM

In order to receive a quote, please return your completed form via email to info@protectyourbusiness.com or by fax to 813-222-4288.

Your Name_____ FEIN/SS#_____

☐ Individual ☐ Corporation ☐ LLC ☐ Partnership ☐ "S" Corp ☐ Other _____

Practice Name_____

Mailing Address_____

City_____ County_____ State_____ Zip_____

Primary Practice Location ➊ *Number of total locations of practice* ➲ _____

Street Address_____

City_____ County_____ State_____ Zip_____

Hours Practiced Per Week_____ Years in Practice (with Worker's Comp coverage) _____

Web Address: www._____

Phone _____ Fax _____ Email Address_____

Best Way to Contact ☐ Phone ☐ Email ☐ Fax

Contact Person_____ ☐ Now ☐ Closer to My Expiration Date

➲ *Attach a copy of your last declarations page(s):*

Current Carrier_____ Current Premium_____

Current Limits_____/_____ Current Deductible_____

Current Expiration Date _____ Requested Effective Date_____

➊ *Number of employees. Please Include ALL officers of a corporation in this count.*

Name	Class Code	Name	Class Code	Name	Class Code
Total Number of Full-Time Employees		Total Number of Part-Time Employees		➲ Employees: Attach list of additional employee names.	

Gross Annual Staff Payroll	$	Full Time Employees	#	Part-Time Employees	#
	$	Myself			
GRAND TOTAL	**$**	☐ Exempt Me ☐ Do Not Exempt Me			

For more information on Workers Compensation Coverage, Contact:

Professional Services Plans
Toll Free: (800) 467-8734
Fax: (813) 222-4288
Email: info@protectyourbusiness.com
www.protectingdentists.com