

Workers Compensation Indication Form

Name of Firm _____ Tax ID # _____

Please complete the following questions for pricing .

Date of coverage to start _____

Employee Name	Classification <small>Architect/Engineer/Draftsman/Clerical/other</small>	Income	Age
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____

Owners, Officers	Classification <small>Architect/Engineer/Draftsman/Clerical/other</small>	Income	Age	Include/Exclude
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____

Return to our office upon completion Fax 623 465 5933

Email to insurance@pibinc.com