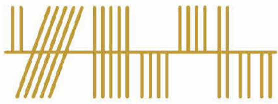

DRISCOLL
Workers Comp Check Up

Send Completed Quote Form to:
(562) 252-8711 or kerry@driscollinsured.com
or complete at driscollinsured.com/service

BUSINESS PROFILE

Business Name: ______________________________

Address: ______________ City: ______________ State: ______ Zip Code: __________

OPERATIONS

1. Have your operations changed at all? ☐ Yes ☐ No
   If yes, please explain. ______________________________
2. Any change in ownership or entity type? ☐ Yes ☐ No
   If yes, please explain ______________________________
3. Do you provide healthcare benefits and pay at least 50% of the cost? ☐ Yes ☐ No
   If yes, would you like to Save 10% by integrating your Group Health with Work Comp? ☐ Yes ☐ No
4. Do you have a Return to Work Plan for injured workers? ☐ Yes ☐ No
5. Do you lease, contract, or hire temporary employees/labor? ☐ Yes ☐ No
   If yes, please list outsourcing agency and send Certificate of Insurance.
   ____
6. Please list membership in any "Trade" Associations: ______________________________
7. Do you participate in or plan to in any OCIP, CCIP or Wrap-Up Programs? ☐ Yes ☐ No

Please provide an estimate of the annual payroll and # of employees, excluding owners/officers, for the coming year.

Class Code	Description	# Full Time	# Part Time	Est. Ann Payroll

This Form was completed by (please print) ______________________ **Title** ____________

Signature:______________________ **Date:** ________________

Phone: ______________________ **Email:** ______________________

I have questions and would like to schedule a phone or office visit to discuss my insurance. ☐ Yes ☐ No

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Tell your friends about us and receive $5 CASH!
We always ask our new customers who referred them to our agency. If someone we ask gives us *your* name, we will send you a $5 bill!
Qualified Referrals*