Post Office Box 1967
Madison, MS 39130-1967
Fax: 601-707-1035

Phone: 601-898-8464
Toll Free: 1-866-238-6922
www.sportsfitness.com

WORKERS COMPENSATION APPLICATION

1. Trade Name: _____
2. Exact Business Name: _____
3. [ ]Individual [ ] Partnership [ ] Corporation [ ]LLC [ ] Other (specify)
4. Street Address: _____
   (separate application for each location - attach separate sheet of paper listing addresses of other locations)
5. City: _____
   State: _____ Zip: _____ County: _____
6. Phone: _____ Fax: _____ Email: _____
7. Mailing Address: _____
8. Federal ID#: _____ No. Yrs. In Business: _____
9. Desired Effective Date: _____
10. Rating Information **Current Experience Mod (if known):** _____

# Employees	Annual Payroll

Minnesota Unemployment # _____

New Jersey TIN # _____

11. Limit of Employers Liability [ ] Statutory

12. Persons to be Included or Excluded: (Partners, Officers, Relatives)

Officers Names	Include or Excludes Remuneration
#	
#	
#	

* Note: Are owner to be included? _____ Do owners have their own health insurance? [ ]Yes [ ]No

13. Has any carrier canceled or declined coverage during the past Year? [ ]Yes [ ]No
    If yes, Name carrier and explain: _____
14. Name of Current Carrier: _____ Policy Number: _____
Policy Period from _____ to _____
15. Claim Experience for the past years: (attach separate sheet if necessary)

Date of Loss	Name	Description	Amount Paid	Days Lost

Application contains a description of all hazards known by me to exist on this date and those likely to exist at any time during the policy period. Any application containing false information would be considered fraudulent and is subject to criminal penalties.

Applicant's Printed Name: _____ Date: _____

Applicant's Signature: _____