Workers Compensation Marketing Questionnaire: DENTAL OFFICE

Name of Client: ____ EFF Date: ________________

Contact Person: ____ Phone: ___________________________

Fax: __________________________________ Email: ____

Federal ID: _______________________________ State ID: _______________________________________

Mailing Address: ____

Location Address: ____

Years in Business: _______________________ Current Insurance Company: ___________________________

Current Premium: __________ Loss History: ____

Payroll

Class or Description of Job: **(8839 Dentists)**	# of Employees	FT/PT	Est. Annual Payroll
Dentists & Dental Surgeons-All Employee's	________/________	_______	__________________

#of Drs: ___________ #of Chairside Assistants: ___________ # of Clerical: _____________

COMPANY OFFICERS

Name: ____ Title: ________________ Ownership %: _______________

Included______ Excluded_______

Name: ____ Title: ________________ Ownership %: _______________

Included______ Excluded_______

HIRING PRACTICES:

Complete Applications	Y/N	Drugs/Substance Abuse Test	Y/N
Reference Checks	Y/N	Pre/Post Employment Physical	Y/N

GENERAL:

Hours of Operation ________ to ________ # Shifts per Day ________ # of Days per Week ________

SAFETY:

COMMENTS:

Workers Compensation Marketing Questionnaire: DENTAL OFFICE

Full Time Safety Director Y/N Name: ____________________PH____________________

Safety Meetings Conducted Y/N How Often: ________________________

HEALTH CARE: Do you Provide Health Care? Y/N % Contributed ______ Provider: __________

Who is Eligible? Full Time ( ) Part Time ( ) 30 Days ( ) 60 Days ( ) 90 Days ( )

% of Employees Covered? _______________________

COMMENTS: