Submit Questionnaire

Cannabis INSURANCE PROS

Workers Compensation Quote Questionnaire

Business Name: _____

Entity Type: ☐ Corp ☐ LLC ☐ Partnership ☐ Individual ☐ Other

Contact Person: _____

Telephone: _____ Fax: _____

E-Mail: _____ Other: _____

Description of Operations

Tell us about your company

Business Address: _____ _____ _____

Mailing Address: _____ _____ _____

Year Started: _____ FEIN: _____ Website: _____

Employee Information

Employee Type	Job Description	Annual Payroll Estimate
1		
2		
3		
4		

Total Number of Employees: _____ Number F/T: _____ Number P/T: _____

Cannabis INSURANCE PROS

Loss/Claim History

(skip this section if none)

Date of Loss/Claim	Description of Claim	Amount Paid

Owner Information

Name	Job Description	Included or Excluded?