

WORKERS' COMPENSATION INFORMATION

Company Name: _____

Federal ID Number: _____

Please confirm the officers of the company:

Please indicate whether the officers are **included or excluded** from coverage.

Does the company have a formal safety program? ____ If so, please provide us with a copy if possible. Otherwise, a table of contents or executive summary will suffice.

Is the company certified by the state of Georgia as a "Drug Free Workplace"? If so, please provide a copy of the certificate.

Is any work subcontracted to uninsured subs? _____ If so, please explain.

Please provide estimated payrolls by classification and state for the coming year on the attached form.

Please provide a copy of the most recent Experience Rating Modifier (ERM) worksheet you recently received from NCCI.

