SPORTS & FITNESS INSURANCE CORPORATION

Post Office Box 1967
Madison, MS 39130-1967
www.sportsfitness.com

Phone: 601-898-8464
Toll Free: 800-844-0536
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WORKERS COMPENSATION APPLICATION

1. Trade Name:_____
2. Exact Business Name:_____
3. ☐Individual ☐Partnership ☐Corporation ☐LLC ☐Other *(specify)*_____
4. Street Address:_____

(A separate application for each location is required)

5. City:_____
   State:_____ Zip:_____ County:_____
6. Phone:_____ Fax:_____ Email:_____
7. Mailing Address:_____
8. Federal ID#:_____ Number of years in business:_____
9. Desired Effective Date:_____ Number of yrs mgmt experience:_____
10. # of Employees: Annual Payroll*

_____

_____

_____

11. Limit of Employers Liability: ☐ Statutory ($100/100/500) ☐ $500,000 ☐ $1,000,000

12. Persons to be Included or Excluded: (**Partners, Officers, Relatives)
LIST **ALL OFFICERS EVEN IF THEY DO NOT WORK AT THE CLUB**
Officers Names: *Does Payroll Above **Include or Exclude** Remuneration for Officers?
#_____
#_____
#_____
Are owners to be included? ☐ Yes ☐ No Do owners have their own health insurance? ☐ Yes ☐ No

***{If new business, skip 13-15}**
13. Has any carrier canceled or declined coverage during the past 3 years? ☐ 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 3 years: *(attach separate sheet if necessary)*

Date of Loss	Name	Description	Amount Paid	Days Lost

Rating Information: Current Experience Mod *(if known)*:_____

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:_____