



KACo Workers Compensation Fund New Business Quote

Fax to: 502-875-8240

Name: _____

FEIN: _____

Contact Name: _____ Title: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

Type of business: _____

Desired Effective Date of Coverage: _____

**Class Codes for Employees	Estimated Annual Payroll	# of Employees
1.		
2.		
3.		
4.		
5.		
6.		
7.		

(Attach an additional sheet if necessary)

- It is very important that we have your **most current** experience modification factor – this can be obtained from your insurance carrier if you do not have this information readily available.
- Please attach at least three years of loss information to this application – this too can be obtained from your current and/or past insurance carriers.
- Providing additional information concerning your current and past workers compensation coverage will also prove beneficial, such as policy pricing and the names of your insurance carriers for the past three years.

***If class codes are not available, please provide **VERY BRIEF** job descriptions of your employees by job category.*

Signature: _____ Date: _____

"Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime."