WORKERS COMPENSATION APPLICATION

submissions@apicannabis.com • (800) 860-8330 • www.apicannabis.com

Effective Date:

Business Name (Legal):

DBA:

Insured's Name:

Date of Birth:

Type of Business Entity: ☐ Corporation ☐ LLC ☐ Partnership ☐ Individual/Sole Proprietor

☐ Other:

Business Address:

City:

State & Zip:

Mailing Address:

City:

State & Zip:

Website:

Phone:

Email:

Expected Annual Sales:

Year Business Started:

FED Tax ID:

Total Employee Annual Payroll:

Number of Employees:

FT:

PT:

Business Description:

Are all Business Officers being included in Coverage? ☐ Yes ☐ No

Total Expected Salary of Officers Included in Coverage:

How Many Officers/Owners? ☐ Sole Owned ☐ Multi Owned: #

List All Excluded Officers (Name, Date of Birth, Title, % Ownership, Duties):

How long has the business had active Workers Comp Insurance?

Current Policy Expiration Date:

Current Insurance Company:

Current Premium:

Prior Claims: ☐ Yes ☐ No If Yes, Please Provide the Date and Details Below:

If You need to add an Additional Insured, please list below:

Name of Additional Insured:

Relationship of Additional Insured:

Street Address:

City:

State & Zip:

AI Requirement: Please Mark If Required by Additional Insured: ☐ Waiver of Subrogation

Do You Have 50% Interest in Another Business? ☐ Yes ☐ No

If Yes, Please Specify:

Additional Insurance:

Would You Like a Quote For: *(Please mark)*

- ☐ Commercial General Liability Insurance
- ☐ Business Owners Policy Insurance
- ☐ Employees Practices Liability Insurance (EPLI)
- ☐ Cyber Liability Insurance
- ☐ Umbrella/Excess Liability Insurance
- ☐ Directors & Officers Insurance (D&O)
- ☐ Commercial Auto Insurance

Please email the application to submissions@apicannabis.com