



Best Choice Insurance Agency
 3701 North St. Peters Parkway Ste A
 St. Peters, MO 63376
 Ph: 636-229-4510 Fax: 636-229-4810
 Email: service@bestchoiceinsurance.com
www.bestchoiceinsurance.com

WORKERS COMPENSATION FORM

Fill in form & print then FAX TO: 636-229-4810

ATTN: Pamela Hopper or Mike Boone

or

**Fill in form, save to computer and email to
service@bestchoiceinsurance.com**

*First Name:	<input type="text"/>	Last Name:	<input type="text"/>
*Address:	<input type="text"/>	*City:	<input type="text"/>
		*State:	<input type="text"/>
		*Zip:	<input type="text"/>
*Phone:	<input type="text"/>	*Email:	<input type="text"/>
		*Best method of contact:	<input type="radio"/> Phone <input type="radio"/> Email
* Year business started:	<input type="text"/>	FEIN#:	<input type="text"/>
Is this a seasonal business or one-time event?	Yes <input type="radio"/> No <input type="radio"/>		
* Approximate amount of workers compensation claims paid in the last 3 years:	<input type="text" value="None"/>		
What is your business legal entity?	<input type="text" value="Make a Selection"/>		
What industry is your company in?	<input type="text"/>		
* Description of the nature of business: (Please be as detailed as possible)	<input type="text"/>		
* Describe the job function of employees:	<input type="text"/>		
Does your business offer health insurance to the employees?	Yes <input type="radio"/> No <input type="radio"/> If Yes, Renewal Month of Health Plan:		
	<input type="text" value="Select a Month"/>		
* Please list your most recent calendar year gross payroll:	<input type="text" value="Make a Selection"/>		
<input type="button" value="Clear Form"/>			