Brokers Logo

**DATE:** March 9, 2018

**TO:** Insured  
Attention: Contact Person

**FROM:** Name

Company

Phone: Fax:

Email:

## RE: Workers’ Compensation Insurance Proposal

The following Workers Compensation quotation is valid for 30 days. This quotation is being offered on the basis shown below and may not necessarily provide the terms and/or coverages requested in your submission. Please review carefully.

IMPORTANT: INSURANCE COVERAGE IS NOT BOUND. In order to bind Insurance coverage, we will require your written request to bind per the terms and conditions of the foregoing quotation. The request must be received in our office on or before the required effective date of insurance coverage

|  |  |  |
| --- | --- | --- |
| **Coverage** | **Insurance Company** | **Proposed Policy Term** |
| Workers’ Compensation | Insurance Company Name | 3/8/2018 – 3/8/2019 |

**Billing Terms**

The down payment amount is due at binding; an invoice is included. Any installments thereafter are eligible for direct bill. Invoices will be mailed direct from Insurance Company Name.

**Binding Subjectivities**

Prior to Binding:

* Written order to bind coverage including effective date
* Signed quote sheet

**Underwriting Notes**

* Please refer to the attached quotation for specific coverage
* Policy is subject to payroll audit, changes in payroll will result in premium modification
* Confirmation of Owners/Officers. Named Owners/Officers will be automatically excluded unless coverage is requested to be included
* Any undisclosed Owners/Officers will be included at time of audit and an additional premium will be charged

Claims

Once coverage is bound, a claims kit will be mailed to you.

Insurance Proposal

**Worker’s Compensation**

**DATE:** Date

**PROPOSED**

**INSURED:** Named Insured

## RE: Worker’s Compensation Insurance Proposal

**PROPOSAL   
VALID FOR:** 30 Days

IMPORTANT: INSURANCE COVERAGE IS NOT BOUND. In order to bind Insurance coverage, we will require your written request to bind per the terms and conditions of the foregoing quotation. The request must be received in our office on or before the required effective date of insurance coverage.

**Proposed Coverage Limits**

Insurance Company Name

$ 1,000,000 Each Accident

$ 1,000,000 Disease- Policy Limit

$ 1,000,000 Disease- Each Employee

**Billing Terms**

The initial down payment plus fees is required in the amount of $000.00 and there will be 9 installments billings of $ooo.oo. Insurance Company Name will bill you directly for the remaining installment payments. Please make down payment payable to; CID Insurance Programs or Insurance Company Name.

Please bind Worker’s Compensation coverage as proposed:

Signature Bind Effective Date

Name (Print) Title *.*

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| **INVOICE** | | | | | | | |
|  | **c/o:** | Insured Name | |  | **Phone:** |  | |
|  | **Attn:** | Contact Person | |  | **Fax:** |  | |
|  |  |  |  |  | **E-mail:** |  | |
| **Policy Description** | | | | | | **Charge** | **Credit** |
| Insured: | | Insured Name | | | |  |  |
| Company: | | Insurance Company Name | | | |  |  |
| Policy Number: | | # | | | |  |  |
| Policy Term: | | Annual | | | |  |  |
| Coverage: | | Workers’ Compensation | | | |  |  |
| Transaction: | | New Business Down Payment | | | |  |  |
| Premium | | | | | | $000.00 |  |
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| **Payable To:** | | **Insurance Company Name** | | | | **Amount Due** | **$000.00** |
|  |  |  |  |  |  |  |  |
| **Mail to:** | | Brokers Information | | |  |  |  |
|  |  | Address: Line 1 | |  |  |  |  |
|  |  | Address: Line 2 | |  |  |  |  |
|  |  |  |  |  |  |  |  |
| **Payment Terms** | | | | | | | |
| • | Down Payment due at time of binding | | | | | | |
| • | It is further understood that flat cancellations cannot be arranged | | | | | | |
| • | Finance agreements are not authorized | | | | | | |
| • |  | | | | | | |
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