



2567 Fairlane Dr, Ste 300  
P.O. Box 240429  
Montgomery, AL 36124-0429

**Healthcare Workers' Compensation  
Self-Insurance Fund**

(334) 271-5515  
1-800-821-9605  
Fax: (334) 270-8314

## REQUEST FOR WORKERS' COMPENSATION QUOTE

Applicant: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_ Type of Business: \_\_\_\_\_

Present Insurance Carrier: \_\_\_\_\_ Expiration Date of Current Policy: \_\_\_\_\_

Experience Modifier (if known): \_\_\_\_\_ **Attach NCCI Worksheet**

Number of Employees: \_\_\_\_\_ Federal ID Number: \_\_\_\_\_

### PAYROLL DATA BY EMPLOYEE CLASSIFICATION:

Employee Classification	Employee Classification Code		Estimated Annual Payroll
_____	_____	\$	_____
_____	_____	\$	_____
_____	_____	\$	_____
_____	_____	\$	_____
_____	_____	\$	_____
_____	_____	\$	_____

If available, please provide a copy of your current Declaration Page.

Mail completed form to: Wayne Averrett  
Healthcare Workers' Compensation Fund  
P.O. Box 240429  
Montgomery, AL 36124-0429

OR FAX TO: (334) 270-8314