SPORTS & FITNESS INSURANCE CORPORATION
Starting Strength GYMS

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Madison, MS 39130-1967
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Toll Free: 800-844-0536
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WORKERS COMPENSATION APPLICATION

1. Trade Name: _____
2. Exact Business Name: _____
3. ☐Individual ☐Partnership ☐Corporation ☐LLC ☐Other (specify) _____
4. Street Address: _____
   (A separate application for each location is required)
5. City: _____
   State: _____ Zip: _____ County: _____
6. Phone: _____ Fax: _____ Email: _____
7. Mailing Address: _____
8. Federal ID#: _____ Number of years in business: _____
9. Desired Effective Date: _____ Number of yrs mgmt experience: _____
10. # of Employees: Annual Payroll*

_____

_____

_____

11. Limit of Employers Liability: ☐ Statutory ($100/100/500) ☐ $500,000 ☐ $1,000,000

12. Persons to be Included or Excluded: (**Partners, Officers, Relatives)
LIST ALL OFFICERS EVEN IF THEY DO NOT WORK AT THE CLUB
Officers Names: *Does Payroll Above Include or Exclude Remuneration for Officers?
_____
_____
_____
Are owners to be included? ☐ Yes ☐ No Do owners have their own health insurance? ☐ Yes ☐ No

*{If new business, skip 13-15}
13. Has any carrier canceled or declined coverage during the past 3 years? ☐ Yes ☐ No
If yes, Name carrier and explain: _____

_____
14. Name of Current Carrier: _____ Policy Number: _____
Policy Period from _____ to _____
15. Claim Experience for the past 3 years: (attach separate sheet if necessary)

Date of Loss	Name	Description	Amount Paid	Days Lost

Rating Information: Current Experience Mod (if known) _____

Application contains a description of all hazards known by me to exist on this date and those likely to exist at any time during the policy period. Any application containing false information would be considered fraudulent and is subject to criminal penalties.

Applicant's Printed Name: _____ Date: _____

Applicant's Signature: _____