



**Workers Compensation Indication**

Agency Name: _____	Phone: _____
Contact: _____	Email: _____
Description of operations: _____	
Location Address: _____	
<hr/>	
Prior Carrier: _____	Lapse in coverage: Y N How many years prior? _____
Class Codes: _____	Payroll: _____
_____	_____
_____	_____
_____	_____
_____	_____

Email: [CL@kinginsuranceca.com](mailto:CL@kinginsuranceca.com)

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