ADROIT
CLEVERLY SKILLFUL
GENERAL AGENCY

WORKERS' COMPENSATION AGENCY APPLICATION

YOUR INFORMATION

First Name: **Last Name:** **Title:**

Phone: **Mobile:** **Email:**

AGENCY INFORMATION

Agency Name:

DBA:

Agency Type: ☐ **Agency/Broker** ☐ **Wholesaler** **FEIN:**

Physical Address:

City: **State:** **Zip:**

Mailing address if different from the address above

Mailing Address:

City: **State:** **Zip:**

WORKERS' COMPENSATION MARKET

Premium volume: **Nbr of accounts:** **Nbr of accounts below $100k:**

Number of producers: **Please list the states you predominantly place business:**

Does your agency/brokerage specialize in a specific industry? ☐ **Yes** ☐ **No**

If yes, please explain:

CARRIER INFORMATION

Please account for 90% of your premium volume.

Carrier	Premium	# of Accounts	5-Year Loss Ratio

COMPANY INFORMATION

Has your agency/brokerage ever had your license suspended, revoked, or otherwise restricted by the Department of Insurance of any state? ☐ **Yes** ☐ **No** **If yes, please explain**

Has your appointment ever been terminated by a carrier? ☐ **Yes** ☐ **No** **If yes, please explain**

Has your agency/brokerage ever had an appointment with Adroit General Agency?

☐ **Yes** ☐ **No** **If yes, please explain**

Have any of the principals, partners, officers, directors, or employees in your agency/brokerage ever been convicted in any state, federal, commonwealth, or territorial jurisdiction of felony crimes involving dishonesty or breach of trust, or any violation of Title 18 U.S.C § 1033?

☐ **Yes** ☐ **No** **If yes, please explain**

PRINCIPALS

Name	Title	Phone	Email

AGENCY CONTRACT SIGNATOR

Name	Title	Phone	Email

THANK YOU FOR YOUR INTEREST IN ADROIT GENERAL AGENCY