

Workers Compensation Insurance

Information Request

Owner Builder Details

Inception Date:

Expiry Date:

ACN:

ABN:

Name:

Business Type (please circle):

Company

Individual

Trust

Contact Details

Postal Address:

State

Postcode

Situation Address:

State

Postcode

Contact Name:

Phone No:

Fax:

Email:

Business Information

What is the main activity of the business? Please provide full details:

What industry is the business involved in?

Estimated number of employees?

Estimated wages?

\$

This is a fact finding form only and the information supplied will be used by an authorised insurer to provide a quotation. If cover is required the insurer will forward directly the cover confirmation and application form for your completion.

Signature: