EL TRIUNFO
Financial & Insurance Services
License #: 0G29333

WORKERS COMPENSATION / HEALTH INSURANCE QUESTIONARE

Date:_____

Prospect's Name: _____

DBA: _____

Address: _____ E-mail: _____

City: _____ State: _____ Zip Code: _____

Contact Info: _____

Contact Phone No.: _____

Number of Employess:

Owners / Officers are Included: Yes_____ No _____

Full Time: _____ Part Time: _____

Current Policy: _____ Proposed Effective Date: _____

Employees Information:

NAME	DOB	JOB CLASSIFICATION	HOW PAID (Wages, Com, Cash)	AMOUNT PAID		RESIDENCE ZIP CODE	N° OF DEPENDENTS
				HOUR / SALARY	WEEKLY / BIWEEKLY		

Note: Zip Code and Dependents applies for Health Insurance only.

Referred by: _____

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