



Pennsylvania Compensation Rating Bureau

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(215)568-2371 • FAX (215)564-4328 • www.pcrb.com

BUREAU INFORMATION QUESTIONNAIRE

FILE NO. _____

(PLEASE TYPE OR PRINT)

1. The following NAME(S) and LOCATION(S) appear on your policy: (Make necessary corrections)

2. Has the above company ever operated under any other name No Yes Explain _____

3. INSURANCE COMPANY

Policy Number _____ Date _____ is the first record of Workmen's Compensation Insurance Coverage this bureau has for your company. List any other Worker's Compensation Policies (past or present) applying to Pennsylvania.

INSURANCE COMPANY _____ Policy # _____ Date _____

INSURANCE COMPANY _____ Policy # _____ Date _____

4. What was the approximate date the above captioned company began operations with employees in Pennsylvania? (Month/Day/Year) _____

5. Please list the NAME(S) of the OWNER(S) or MAJOR STOCK HOLDER(S) of this Company.

6. List all other companies which have the same ownership as the entity in Item 1.

A. Is there any interchange of employees between the entity in Item 1 and the entity(ies) in Item 6?

No Yes Explain _____

B. Is there a continuity of operations between the entity in Item 1 and the entity(ies) in Item 6?

No Yes Explain _____

7. Was the business (Item 1) purchased from another owner? No Yes (If Yes, answer A, B, C and D.)

A. List the previous owners' Name(s) and their Trading Name(s) _____

B. What was the date the ownership change took place? (Month/Day/Year) _____

C. How many previous employees were retained? _____ out of _____ or _____ % retained.

D. When the ownership change took place were there any major changes made in the operations?

No Yes If Yes, please describe on the back of the questionnaire.)

8. Questionnaire completed by (Your Name) _____ Title _____

9. Your Company's Telephone Number: Area Code (_____) _____

10. Your Agent's Name and Telephone Number: Area Code (_____) _____

(PLEASE USE OTHER SIDE FOR ANY ADDITIONAL EXPLANATIONS)