Worker's Compensation Loss History Affidavit

Applicant Company_____Date_____

Owners Name_____ Social Security #_____

Company Address_____

City_____State_____ Zip_____

Federal Tax ID #_____ Phone_____

Description of Operations_____

_____

_____

_____

_____

I, _____, do hereby certify and swear that the company _____

_____ has incurred _____ injuries within the last 36 months.

Please list the injuries and costs incurred in the table below for the last 36 months. **If there have been no injuries, please write NONE in the table.**

Year of Claim	Name of Injured	Amount of Claim	Description injury	Open or Closed

Company Name_____

Company Representative_____ Title_____

Signature_____ Date_____

Note: This affidavit must be submitted with the Applicant Questionnaire when actual loss runs are not available.

Any person who knowingly and with intent to injury, defraud, or deceive any insurer files, statements or claims, or an application containing any false, incomplete, or misleading information with the purpose of avoiding or reducing the amount of premiums for workers compensation coverage or conceal information pertinent to the corporation and application of an experience rating modification factor, is guilty of a felony of the third degree or as otherwise punishable as provided under law.