ATLANTALIFE®
General Agency

Email: ALGA@atlantalife.com
Phone: 404-654-8842
Fax: 404-654-8869

WORKER'S COMPENSATION-REFERRAL FORM

Agent Name: _____

Date: _____

Phone: _____

Business Email: _____

Full Business Name: _____ Years in Business: _____

Business Phone Number: ( ) _____- _____ Contact Person (required)_____

Email : _____

Requested Effective Date: _____ Exact Nature of Business: _____

Legal Entity: Individual _____ LLC_____ _____

Corp_____ Partnership_____ _____

Business FEIN_____ _____

Business Mailing Address _____

City: _____ State:_____ Zip:_____ County:_____

Business Location address if different from above_____

City:_____ State:_____ Zip:_____ County:_____

Annual Payroll $_____

Number of employees: Full-time _____ Part-time_____

Employer Liability Limit

$_____Each Accident

$_____Disease- Policy Limit

$_____Disease-Each Employee

Additional information may be required depending on the nature of the customer's business