**Please provide the requested information below and email this form to** **agencymanagement@employers.com****.**

 **Agency Information**

Agency Name:

Agency Address:

Agency Website: Agency Management System:

**Agency Main Contact Information**

First & Last Name: Title:

Phone Number: Email address:

**Agency Volume and Location**

Number of Agency Locations: Number of Employees:

Total Written Premium ($): Total Workers’ Compensation Premium ($):

Percentage of Commercial Business: Number of Years in Business:

**Opportunities**

Why are you seeking a new Workers’ Compensation Insurance carrier partnership with EMPLOYERS?

What are your top five commercial carriers with direct appointments (by premium size)?
1. 4.
2. 5.
3.

What is your industry focus (e.g. general or niche classes)? If niche classes, please list them below.

**Submission of this form does not guarantee an appointment. Agency appointments are made at the sole discretion of Employers Assurance Company, Employers Compensation Insurance Company, Employers Insurance Company of Nevada and/or Employers Preferred Insurance Company.**