TexasMutual®
WORKERS' COMPENSATION INSURANCE

WORK SAFE, TEXAS®

Supplemental Employee Data Worksheet

Policyholder's name:_____   Policy/quote no. _____

Instructions: In order to help us maintain the accuracy of our policy data, please complete this form and return it as soon as possible. Use one row for each physical business location, and make additional copies if you have more than 10 locations. Thank you for your assistance.

Physical address (no P.O. boxes)	City	State & ZIP Code	Building height (no. Of stories)	No. Of employees by location	No. Of work Shifts	Max no. Of employees per shift
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						

Are there any special events during the year that would place more than 50 people at one time at one of the locations listed above, such as conventions, holiday parties, etc.?   **Yes   No   (circle one)**
If yes, please explain: _____

Name of person completing form: _____ Date: _____
Company name: _____ ◯ Policyholder   ◯ Agent

Please fax or mail completed form to:
Texas Mutual Insurance Company
P.O. Box 12058
Austin, TX 78711-2058
Fax: (800) 359-0650

2/1/17