WORKERS' COMPENSATION INSURANCE CERTIFICATE REQUEST FORM

Client Company Information:

*Company Name: _____

Company Fax #: (_____) _____-_____   *Company Phone #: (_____) _____-_____

Email Address: _____

*Requested By: _____   *Date Requested: _____

Certificate Holder Information: (Required for Certificate to be Issued)

*Certificate Holder Name: _____

*Address: _____

*City: _____   *State: _____   *Zip: _____

Attention: _____

Email Address: _____

Fax #: (_____) _____-_____   Phone #: (_____) _____-_____

Certificates will be mailed via U.S. Mail if a fax or email address is not provided

Project Information: (**Required for Waiver of Subrogation Requests)

☐ Waiver of Subrogation (Please check if a waiver of subrogation is needed)

**Project Name: _____

**Address: _____

**City: _____   **State: _____   **Zip: _____

**Project Start Date: _____   **Scope of Work: _____

(Please submit special requirements received, in writing, from the certificate holder with this request)

*Required Fields – Must be complete in order for certificate to be issued.

Revised 2/8/24