



REQUEST FOR WORKERS' COMPENSATION CERTIFICATE OF INSURANCE

In order to process your request in a timely manner, we request that you provide us with all of the following information:

Insured Name: _____

Fax #: _____

Phone: _____

Certificate Holder: _____

Address: _____

Address 2: _____

City: _____ State: _____ Zip Code: _____

Certificate Holder Fax #: _____

Certificate Holder Email: _____

Project Information: _____

Special requirements: (please select all that apply to the certificate holder(s) request)

- Waiver of subrogation
- Retro (COI for previous policy year) - Policy years needed: _____
- Additional wording for waiver: _____
- Specific certificate holder requirements: _____

Please FAX all request to attention Bethany at 772-692-7987