



THE COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF LABOR AND WORKFORCE DEVELOPMENT
DEPARTMENT OF INDUSTRIAL ACCIDENTS

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PROCESS FOR SUBMITTING
INSURER REQUEST CERTIFICATION FORM

Use this version for a mailed in or faxed (617 624-0985) submission. Responses to faxed requests cannot be faxed back. Use the online version if your e-mail account does not have an attachment filter. Also be advised that any returned online version in need of adjustment requires that a new online form be completely filled out and submitted with the requested adjustment incorporated into it.

1. Print and then fill out the Insurer Request Certification Form that follows.
2. Forward that form to Thomas Finneran at the address indicated at the bottom of the form, or fax it to his attention.
3. If the form has been completed correctly and no coverage is found for the submitted employer name, then a letter will be sent to the submitter's office certifying that name as uninsured, along with an Affidavit of Employee In Application For Trust Fund Benefits document for the employee/claimant to fill out.
4. Attach the Certification Letter, the completed Affidavit (Form 170) and the original (or a completed) Employee Claim (Form 110) and forward to:

OFFICE OF CLAIMS ADMINISTRATION
DEPARTMENT OF INDUSTRIAL ACCIDENTS
1 CONGRESS STREET, SUITE 100
BOSTON, MASSACHUSETTS 02114-2017

INSURER REQUEST CERTIFICATION

1.

I, _____, certify that the following attempts were made to
(Employee Attorney)
_____ to obtain insurer information
(Employer & Employer's Address)
regarding the claim of _____, an employee of that organization,
(Employee)
and that to the best of my knowledge no insurance coverage was in force for that company on
_____.
(Date of Injury)

2.

The following corporate officers/owners were contacted:

NAME/TITLE	PHONE	DAY/DATE/TIME
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

3.

I did approach the place of business.
 I did not approach the place of business. Why not? _____

4.

The employee requested the information from his/her employer.
What was he/she told? _____
By whom? _____

The employee did not request the information from his/her employer.
Why not? _____

All sections of this form must be completed. Any exclusions and/or deletions will be cause for return of the claim application and delay in processing.

5.

Employee Attorney

Attorney Address & Telephone Number

Claimant

This form requires BOTH signatures
Return to: Department of Industrial Accidents
ATTN: Thomas Finneran
19 Staniford St., 5th Floor
Boston, MA 02114