



THE COMMONWEALTH OF MASSACHUSETTS

Department of Industrial Accidents

Office of Insurance

19 Staniford Street, 5th Floor
Boston, Massachusetts 02114

Charles D. Baker
Governor

INSURANCE REGISTER
(617) 626-5480 or (617) 626-5481

Linda Edmonds Turner, Ph.D.
Director

Karyn E. Polito
Governor

INSURANCE INQUIRY 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. (Revised 4/2014)

Please fill out this form legibly, and remember to enter your mailing address at the bottom to receive our researched response.

If the employer name is incorrect, insurance information may not be found. Take the employer name from a payroll, income tax or social security document issued during the calendar year within which the injury occurred.

COMPANY NAME (s) _____

ADDRESS _____

WHAT IS ANOTHER NAME UNDER WHICH THE COMPANY COULD BE OPERATED?

DATE OR PERIOD OF INJURY _____

HOW LONG HAS THE COMPANY BEEN IN BUSINESS? _____

WORKERS COMPENSATION INSURANCE INFORMATION SHOULD BE REQUESTED FROM THE EMPLOYEE'S COMPANY FIRST. CALL AND ASK TO SPEAK WITH THE APPROPRIATE PERSON AT THE COMPANY WHO WOULD HAVE THE KNOWLEDGE OF THIS INFORMATION

IF INSURANCE INFORMATION CANNOT BE FOUND FOR THE EMPLOYER NAME SUBMITTED, SUCH A FINDING DOES NOT NECESSARILY MEAN THAT THE ENTITY WAS NOT OR IS NOT INSURED.

YOUR NAME AND ADDRESS (TO MAIL BACK THIS FORM TO YOU):

