FORM 154

The Commonwealth of Massachusetts

Department of Industrial Accidents
Office of Investigations - Dept. 154
Lafayette City Center, 2 Avenue de Lafayette, Boston, MA 02111-1750

DIA Use Only

VERIFICATION OF MASSACHUSETTS WORKERS' COMPENSATION COVERAGE FOR OUT OF STATE EMPLOYERS OPERATING IN MASSACHUSETTS

Massachusetts law mandates that all employers must provide workers' compensation insurance coverage for their employees. Out of state employers are required to provide Massachusetts workers' compensation coverage for all their employees working in Massachusetts. Employers whose existing workers' compensation insurance policies specifically list Massachusetts in section 3A of said policy's information page, satisfy this requirement.

Please note that employers whose workers' compensation insurance policies specifically list Massachusetts in section 3C regarding all states coverage (with or without certain state exclusions) shall provide verification from their insurance carrier that coverage is provided in Massachusetts. To satisfy this requirement, the insurance carrier must complete this form verifying that the employer meets all the mandatory requirements for indemnity workers' compensation insurance coverage for all employees engaged in the employer's Massachusetts operations. Upon request, this form, a copy of the policy's information page and a copy of any policy clause or clauses, which set forth conditions under which section 3C will become effective, must be submitted to the Office of Investigations of the Department of Industrial Accidents.

PLEASE NOTE THAT THIS FORM MUST BE COMPLETED BY THE INSURANCE CARRIER PROVIDING COVERAGE TO THE EMPLOYER.

INSURED'S INFORMATION

1. Legal Name and Address of the Insured (P.O. Box Not Acceptable):

_____
_____
_____

2. All Massachusetts Work Locations of Insured:

_____
_____
_____

3. Business Telephone Number of Insured:

_____

4. Federal Employer ID Number or Social Security Number of Insured:

_____

- Over -

INSURER'S INFORMATION

1. **Name of Insurance Carrier:**

_____

_____

2. **Name, Address and Telephone Number of Insurance Carrier Contact Person:**

_____

_____

_____

_____

_____

3. **Policy Number of Insured:**

_____

4. **Policy Term:**

_____

5. **List the name of the Proprietor, or all Partners or all Officers of the Insured and check the appropriate box below:**

_____

_____

_____

_____

_____

☐ **All individuals listed above are included in the coverage provided by the insurance carrier.**

☐ **Some of the above listed individuals are excluded from the coverage provided by the insurance carrier. These individuals are:**

_____

_____

_____

_____

This certifies that the insurance carrier listed above provides workers' compensation insurance coverage for its above-named insured's employees in Massachusetts. The information contained herein is true to the best of my knowledge and belief.

Signed under the pains and penalties of perjury.

_____

Signature of Insurance Carrier Representative **Print name** **Date**

_____ _____ _____

Title of Insurance Carrier Representative **Direct Phone Line** **Email Address**