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

OFFICE OF INSURANCE

PROCESS FOR SUBMITTING
INSURER REQUEST CERTIFICATION FORM

Use this version for a mailed 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 this address:

Office of Insurance
100 Cambridge Street, 5th Floor
Boston, MA 02114

or fax it to: (617) 624-0985

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 the 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
Lafayette City Center
2 Avenue de Lafayette
Boston, MA 02111-1750

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
(Employee)
Organization, 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	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

_____
Claimant

This form requires BOTH signatures

Return to: Department of Industrial Accidents
ATTN: Thomas Finneran
100 Cambridge Street, 5th Floor
Boston, MA 02114