

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 in submission. 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 Department of Industrial Accidents Lafayette City Center 2 Avenue de Lafayette Boston, MA 02111-1750

- 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 <u>Affidavit (Form 170)</u> and the original (or a completed) <u>Employee Claim (Form 110)</u> 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,	I,, certify that the following attempts were made (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 that company on (Date of injury)		surance coverage was in force fo
2 . T	he following corporate officers/owne	rs were contacted:	
	NAME / TITLE	PHONE	DATE / TIME
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3.	I did approach the place of busing I did not approach the place of the	ousiness. 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?		
	I sections of this form must be cor use for return of the claim applica		
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