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

OFFICE OF INSURANCE

INSURANCE INQUIRY FORM

Use this version for a mailed in or a document scanned and then e-mailed submission. Use the online version if your e-mail account does not have an attachment filter. (Revised 04/22/2025).

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

If the employer's name is incorrect, insurance information may not be found. Take the employer's 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 MAY BE OPERATING?

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'S NAME AS SUBMITTED, SUCH A FINDING DOES NOT NECESSARILY MEAN THAT THE ENTITIY WAS NOT, OR IS NOT, INSURED.

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

If mailing this form - send to:
Dept. of Industrial Accidents
Office of Insurance
Lafayette City Center
2 Avenue de Lafayette
Boston, MA 02111-1750