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

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

CHARLES D. BAKER
GOVERNOR

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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 11/2014)

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):

_____

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