REQUEST FOR WORKERS' COMPENSATION CERTIFICATE OF INSURANCE

CLIENT INFORMATION

Date Requested: _____ / _____ /_____

Client Name: _____

Requested By: _____

Client Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: (_____) _____ -_____

CERTIFICATE HOLDER INFORMATION

Certificate Holder Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Attention *(optional)*: _____

METHOD OF DELIVERY

☐ Fax — Certificate Holder Number (_____) _____ -_____

Client Number (_____) _____ -_____

☐ Email — Email: _____

☐ Mail — To the certificate holder address above

ADDITIONAL INFORMATION REQUESTED

_____

_____

_____

_____

PLEASE FAX ALL REQUEST FORMS TO (866) 214-9505 or Email: workcomp@employersresource.com

1301 South Vista Avenue, Suite 207 • Boise, Idaho 83705 • (800) 775-2404 • Fax (866) 214-9505