

**DEPARTMENT OF LABOR
DIVISION OF INDUSTRIAL AFFAIRS
INDUSTRIAL ACCIDENT BOARD**

On behalf of the company/individual named below, I/we certify that workers' compensation insurance coverage is in force for all employees as required under the provisions of the workers' compensation laws of this state.

BUSINESS NAME: _____

FED. E.I./S.S. NO.: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

- (1) **CHECK THE APPROPRIATE LINE**
- (2) **COMPLETE NAME OF CARRIER. IF INFORMATION IS CHECKED**

_____ Copy of Certificate of Insurance attached).

_____ Copy of Self-Insurance under Delaware Law attached).

_____ Name of Carrier: _____

Address: _____

Policy Number: _____

_____ I/we have no employees.

Under penalties of perjury, I/we declare that this document is true and correct.

Signature

Date

Title

Division of Revenue is to forward a copy of this form to the Industrial Accident Board upon completion by applicant.