INDUSTRIAL ACCIDENT BOARD
DIVISION OF INDUSTRIAL AFFAIRS

On behalf of the company / individual named below, I (we) certify that the workmen's compensation insurance coverage is in effect for all employees as required under the provisions of the workmen's compensation laws of the State of Delaware:

BUSINESS NAME: _____

E.I.N. / S.S.N.: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

CHECK THE APPROPRIATE BOX:

☐ The business is exempt from the workmen's compensation law: I / we have no employees.

☐ The business is exempt from the workmen's compensation law: I / we employ farm laborers.

☐ The business is a self-insured Employer (copy of certificate of self-insurance attached).

☐ The business has workmen's compensation insurance (provide insurance information below):

Insurance Carrier Name: _____
Insurance Carrier Address: _____
Insurance Policy Number: _____

CONSTRUCTION INDUSTRY ONLY:

☐ Sole Proprietor / Partner working as an independent contractor as per 19 *Del. C.* § 2311:

- ☐ Copy of Certificate of Insurance attached.
- ☐ Covered under General Contractor's policy.
- ☐ Limited liability corporation (LLC) maximum four members.

Under penalties of perjury I (we) declare that this document is true and correct:

_____ _____
SIGNATURE TITLE / DATE

Division of Revenue is to forward a completed copy of this form to the Industrial Accident Board.
For assistance in completing this form please call the Industrial Accident Board at: Wilmington: (302) 761-8200; Dover: (302) 422-1392.