

## 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:			
		CIT	Y, STATE, ZIP:
		CHE	ECK 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:		
CON	NSTRUCTION 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.		
Unde	er 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.