

INSURANCE INFORMATION FORM

Worker's Compensation Insurance Information

Provide the following information in compliance with the Labor and Employment Article, §9-201 et seq., Annotated Code of Maryland.

Do you employ one or more persons full or part time? Yes No

If the answer is NO, sign and date the form, and return it with your application.

If the answer is YES, check (A) or (B) below and complete the information needed. Then sign and date the form and return it with your application.

IF YOU ANSWERED YES, YOU MUST:

A) Attach a copy of your Worker's Compensation Insurance Policy statement page.
You must include the effective and expiration dates.

Or

B) Complete the information below about your Worker's Compensation Commission policy or binder number.

1) Policy or Binder Number: _____

2) Insurance Company: _____

3) Effective Date: _____

4) Expiration Date: _____

Signature: _____

Title: _____

Date: _____

County: _____

Name of Center: _____

If you have questions about Workman's Compensation, contact your insurance carrier or Workman's Compensation Commission.