Reset

Print Form

DELAWARE DEPARTMENT OF LABOR
OFFICE OF WORKERS' COMPENSATION

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

Name of Employer _____

Fed. E.I./S.S.# _____

Address _____

City, State, Zip _____

CHECK THE APPROPRIATE LINE:

☐ I/we have no employees

☐ I/we have employees (complete insurance information below):

Name of Insurance Carrier _____

Construction Industry Only:

☐ Sole proprietor/partner working as an independent contractor pursuant to 19DelC§2311:

- ☐ Provide name of insurance carrier (see above)
- ☐ Covered under general contractor's policy
- ☐ Limited liability corporation (LLC) maximum 4 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 Office of Workers' Compensation.

For assistance in completing this form please contact the Office of Workers' Compensation at:
Wilmington ***302-761-8200*** *Milford* ***302-422-1392***