WORKER’S COMPENSATION VERIFICATION

Workmen’s Compensation Policy Number: ______________________________

Effective Date of Policy: ______________________________

Name of Insurance Company: ______________________________

Address of Insurance Company: ______________________________

If you are not required to be covered under Worker’s Compensation,
please state the reason:

____

Are you self-employed? ______________________________

Number of employees: ______________________________

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT
TO THE BEST OF MY KNOWLEDGE.

__________________________________ ______________________________
Date Signature

__________________________________ ______________________________
License/Class Number Printed Name