



## ***Request for Worker's Comp Certificate of Insurance***

Attn: Risk Management Dept.

Date: \_\_\_\_\_

Fax: (956) 928-0963 / (888) 869-9176

Client Co: \_\_\_\_\_

Client E-mail/Fax: \_\_\_\_\_

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*Please fill out the information below to request a certificate of insurance. Fax completed request to number listed above.*

Certificate Holder Name: \_\_\_\_\_

Attention: \_\_\_\_\_

Address: \_\_\_\_\_

Project/Job Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Type of Insurance Certificate: ***Worker's Comp***

Waiver of subrogation on Workers' Compensation?      Yes \_\_\_\_\_      No \_\_\_\_\_

Additional Job/Project Information needed:

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**(FOR OFFICE USE ONLY)**

Date Received from Client: \_\_\_\_\_      Date Requested: \_\_\_\_\_      Date Received: \_\_\_\_\_

Date Faxed (Client) \_\_\_\_\_      Date Faxed (Certificate Holder) \_\_\_\_\_