STAR HR

WORKERS' COMPENSATION INSURANCE CERTIFICATE REQUEST FORM

Client Company Information:

Company Name: _____

Company Fax: _____ Company Phone: _____

Requested By: _____ Date Requested: _____

Certificate Holder Information:

Certificate Holder Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Attention: _____

Fax: _____ Phone: _____

Complete address and fax number are required to issue certificate.

Jobsite Location: _____

Project Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

PLEASE COMPLETE THIS CERTIFICATE REQUEST FORM

AND Fax to: 844-325-0415 or Email to: risk@starhro.com

Please allow up to 24 hours to process your request.