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.