

WORKERS' COMPENSATION INSURANCE COVERAGE INFORMATION

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INSURANCE INFORMATION

Name of Applicant \_\_\_\_\_

Federal or State Employer Identification Number \_\_\_\_\_

Applicant is a qualified self-insurer for workers' compensation.

Certificate attached

Name of Workers' Compensation Insurance \_\_\_\_\_

Workers' Compensation Insurance Policy Number \_\_\_\_\_

Certificate attached

Policy Expiration Date \_\_\_\_\_

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EXEMPTION

Contractor with no employees

Religious exemption under the Workers' Compensation Law

The undersigned swears or affirms that he/she is not required to provide workers' compensation insurance under the provisions of Pennsylvania's Workers' Compensation Law (Act 44 of 1993) for one of the reasons above.

Subscribed and sworn to before me this  
\_\_\_\_\_ day of \_\_\_\_\_, 200\_\_

Signature of applicant \_\_\_\_\_

\_\_\_\_\_  
(Signature of Notary Public)

Address \_\_\_\_\_

My commission expires: \_\_\_\_\_

Telephone No. \_\_\_\_\_

(Seal)

Municipality of \_\_\_\_\_