Pennsylvania
Department of Labor & Industry
Bureau of Workers' Compensation

EMPLOYER'S CERTIFICATE OF INSURANCE

THE FOLLOWING INFORMATION MUST BE FURNISHED TO THE BUREAU AS EVIDENCE OF COMPLIANCE WITH SECTION 305 OF THE PENNSYLVANIA WORKERS' COMPENSATION ACT

Number of Pennsylvania Employees (required)

PA Employer Account Number (required)

Church/ Daycare Name

XX-XXXXXXX

Business Name: (required)

Federal Employer Identification Number (required)

Street Address: (required)

City/Town (required)

State (required)

ZIP (required)

IF YOU HAVE WORKERS' COMPENSATION INSURANCE:

☐ Check if policy information is for a renewal of a previous policy

Workers' Compensation Insurance Company name

NAIC # (located on policy)

Policy number

Policy effective start date

Policy effective end date

INSURANCE AGENT INFORMATION

Name

Street Address

City/Town

State

ZIP

Telephone

IF YOU DO NOT HAVE WORKERS' COMPENSATION INSURANCE: (required) (check only one)

☐ Out of business Company out of business date (if applicable) _____

☐ Zero employees-(ex: sole proprietor, LLC members and general partners (not corporations)

☐ Corporation with zero employees and all executive officer(s) excepted (Must file forms LIBC-509 and LIBC-513)

☐ Only employs domestics or religious employees considered exempt under the Act

☒ Other: Self Insured UMWC Trust Permit 5522

I, the undersigned, verify that I am authorized to sign on behalf of the above named business. I further verify that the facts set forth in the Employer's Certificate of Insurance are true to the best of my knowledge, information and belief. These verifications are made subject to the penalties of 18 PA.C.S. §4904, relating to unsworn falsification to authorities.

Signature (required) _____

Date (required) _____

First name (required) _____

Employer's telephone (required) _____

Last name (required) _____

Email address (required) _____

Title (required) (ex: Corporate CEO or other corporate office; Partner or Sole Proprietor) _____

SUBMIT COMPLETED FORM TO:

Department of Labor & Industry
Bureau of Workers' Compensation Compliance Division
651 Boas Street
Harrisburg, PA 17121-0750
Online: www.wcais.pa.gov
Email: ra-libwc-compliance@pa.gov

Any individual filing misleading or incomplete information knowingly and with the intent to defraud is in violation of Section 1102 of the Pennsylvania Workers' Compensation Act, 77 P.S. §1039.2, and may also be subject to criminal and civil penalties under 18 Pa. C.S.A. §4117 (relating to insurance fraud).

Compliance Division	**Claims Information Services**	**Hearing Impaired**	**Email**
717.787.3567	toll-free inside PA: 800.482.2383 local & outside PA: 717.772.4447	PA Relay 7-1-1	ra-libwc-compliance@pa.gov

Auxiliary aids and services are available upon request to individuals with disabilities.
Equal Opportunity Employer/Program