

## Coverage Research Service Request Form 807 (Rev. 05/2015)

# Instructions

### Purpose of Form

Completion of this form is required for coverage requests made in connection with a pending workers' compensation claim. It may also be used by employers or insurers to request their own coverage information.

### Use of Form

The WCIRB can provide coverage information to an insurance company, employer, injured worker, licensed health care provider, Third Party Entity (TPE) acting on behalf of a member insurer who has a TPE agreement with the WCIRB or an attorney involved in a pending workers' compensation claim.

### Authorization

Before the coverage request will be processed, the requesting party must certify that he/she is entitled to receive the information, that the information will be used solely in connection with the pending workers' compensation claim and that the information will not be otherwise published, distributed or released to third parties other than in connection with the administration and/or litigation of the pending workers' compensation claim.

Employers or insurers may have access to their own information even if there is no pending workers' compensation claim.

### Coverage Availability

The WCIRB is unable to supply coverage information prior to 1958.

### Information Requirements

The WCIRB will not process your coverage research service request unless all sections of the form are completely filled out.

The requesting party must provide the WCIRB with necessary information regarding the pending workers' compensation claim for which the information is sought, including the name of the parties, date of injury, claim number (if known) and WCAB number (if assigned). Incomplete information will delay the completion of your request.

### Form Completion

- This form can be completed electronically; however, the form **requires a signature** and must be printed and signed by an authorized individual.
- If not completed electronically, print or type all information.

- Under Coverage Information Requested, list both the physical address and the P.O. Box address, if the employer uses a P.O. Box. The WCIRB can only provide coverage information when the employer's address matches the address on the policy record.

### Fees

The fee for coverage research is **\$10.00 per year, per employer**. Any portion of a year counts as a complete year.

### Fee Examples

The examples are based on one employer.

Coverage Requested	Total No. Years	Fee
2009–2010	2	\$20
1/1/09–1/1/10	1	\$10
1/1/09–1/31/10	2	\$20
2009–3/1/12	4	\$40
2008–20012	5	\$50

### Payment

Payment must be received before your request can be processed and is non-refundable. Calculating the correct fee for your request will expedite your order.

**If you need assistance in calculating the fee, call WCIRB Customer Service.**

- WCIRB member insurers may elect to be billed.
- TPEs, authorized by WCIRB member insurers, may elect to have the WCIRB bill the member insurer. The WCIRB is unable to bill TPEs directly.
- For all others, the WCIRB accepts payment by check only. Include your payment when submitting the Coverage Research Service Request form.

### Delivery

MAIL Coverage research requests are mailed.

EMAIL Email delivery is available (see page 2).

### Form Submission

This form must be mailed to the WCIRB.

MAIL WCIRB Customer Service  
Attn: Coverage Department  
1221 Broadway, Suite 900  
Oakland, CA 94612

### Questions

Call WCIRB Customer Service toll free  
888.CA.WCIRB (229.2472) 7:30 a.m.–5:00 p.m. PST

All products and services are prepared by the WCIRB in the normal course of business pursuant to the regulations of the California Department of Insurance or for the benefit of the WCIRB's members. The WCIRB has made reasonable efforts to ensure the accuracy of the products and services.

You must make an independent assessment regarding the use of all WCIRB products and services based upon your particular facts and circumstances. The WCIRB cannot make such an assessment and shall not be liable for any damages, of any kind, whether direct, indirect, incidental, punitive or consequential, arising from the use, inability to use, or reliance upon WCIRB products and services.

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Original signature required. This form must be mailed.

## Pending Workers' Compensation Claim Information

Injured Worker	Date of Injury
Employer	WCAB Number (If Assigned)
Insurer (If Known)	Claim Number (If Known)

## Requesting Party Information

Print Name of Individual Requesting Information	Title/Position	
Company OR Injured Worker Represented	Telephone	
Address (If Injured Worker, Include Your Own Address)	If an Attorney, Indicate Party Represented	
City	State	Zip
Email Address (Required for Email Delivery)		

## Coverage Information Requested [For additional employers, attach separate sheet(s).]

The WCIRB is unable to supply coverage information prior to 1958.

List the physical address and if the employer has a P.O. Box, the P.O. Box must also be included.

(1)	(2)
Employer	Employer
DBA (If Known)	DBA (If Known)
Coverage Year(s) Requested	Coverage Year(s) Requested
<b>Physical Address</b>	<b>Physical Address</b>
Physical Address City	Physical Address City
Physical Address State	Physical Address State
Zip	Zip
<b>P.O. Box Address</b>	<b>P.O. Box Address</b>
P.O. Box City	P.O. Box City
P.O. Box State	P.O. Box State
Zip	Zip

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### Certification

The requesting individual hereby certifies that he/she is:

- the injured worker in the pending workers' compensation claim; **OR**
- an employee, partner, manager, officer or director of, and has the authority to bind, an employer, as defined by Labor Code 3300, in the pending workers' compensation claim; **OR**
- a licensed workers' compensation insurance insurer in the pending workers' compensation claim; **OR**
- an employer, as defined by Labor Code Section 3300, in the pending workers' compensation claim; **OR**
- a licensed health care provider in the pending workers' compensation claim; **OR**
- a Third Party Entity (TPE) that is authorized to obtain coverage information by a member insurer in the pending workers' compensation claim; **OR**
- an attorney representing any of the above individuals or entities in the pending workers' compensation claim.
- an employer, as defined by Labor Code Section 3300, or an insurer requesting their own information, or an attorney representing an employer or insurer. (If this box is checked, a signature is not required below.)

### Restricted Use of Information if Requested in Connection with a Pending Workers' Compensation Claim

I agree that the coverage information provided shall be used solely in connection with the administration and/or litigation of the above-referenced pending workers' compensation claim, and for no other purpose. In addition, I agree that the information provided by the WCIRB is confidential and proprietary and shall not be published, distributed, released or communicated to third parties, other than in relation to the administration and/or litigation of the above-referenced pending workers' compensation claim. I affirm that all information provided on this form is true and correct.

Signature \_\_\_\_\_

Date \_\_\_\_\_

### Fees

List the amount being paid. Refer to the chart under Fee Examples on the Instruction page.

\$ \_\_\_\_\_

Please complete page 3.

# Coverage Research Service Request

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### Payment Method — Members and TPEs

WCIRB Member Billing.

I am authorized by the insurer named in the Requesting Party Section of this form to request insurance policy information. I understand that my company will be billed for the information ordered by this form.

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Authorized by	Authorized Signature Required
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Title	Date
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Member Authorized TPE. (Member will be billed. Include member billing information below.)

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Authorized by	Signature
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Title	Date
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Member Company

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Address

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City	State	Zip
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### Payment Method — Others

The WCIRB accepts payment by check only. Make your check payable to "WCIRB" and mail to the address on this form.

Check enclosed (non-refundable).

### Email Delivery

Check this box for email delivery as an alternative to receiving via U.S. Mail.