THE WORKERS' COMPENSATION
RATING AND INSPECTION BUREAU

November 1, 2010

CIRCULAR LETTER NO. 2165

To All Members and Subscribers of the WCRIBMA:

DEPARTMENT OF INDUSTRIAL ACCIDENTS' REVISED FORM 154 FOR VERIFICATION OF OUT-OF-STATE WORKERS' COMPENSATION COVERAGE

Attached is a revised copy of the Department of Industrial Accidents' Circular Letter No. 335, dated October 28, 2010, announcing a revised form for verifying out-of-state workers' compensation coverage. *This WCRIBMA Circular Letter No. 2165 supersedes WCRIBMA's Circular Letter No. 2160.*

Any questions regarding this new form should be directed to Ray Marchand, Director of Investigations, at 617-727-4900 x413.

DANIEL M. CROWLEY, CPCU
Vice President – Customer Services

Attachment

THE COMMONWEALTH OF MASSACHUSETTS
Department of Industrial Accidents

1 Congress Street, Suite 100
Boston, Massachusetts 02114-2017

DEVAL L. PATRICK
Governor

TIMOTHY P. MURRAY
Lieutenant Governor

PAUL V. BUCKLEY
Commissioner

CIRCULAR LETTER #335 - AMENDMENT

TO: All Interested Parties

FROM: Paul V. Buckley, Commissioner

RE: Amended Circular Letter #335 - Form for Verification of Workers' Compensation Coverage for Out-of-State Employers Operating in Massachusetts

Date: October 28, 2010

This Amended Circular Letter is in place of and supersedes Circular Letter #335 issued on August 26, 2010.

The Department of Industrial Accidents (DIA) has promulgated a new form to be used by employers located in other states but conducting business and employing workers in Massachusetts. Form 154 – Verification of Massachusetts Workers' Compensation Coverage for Out-of-State Employers Operating in Massachusetts (amended Form 154 attached) will be completed by said employer's workers' compensation insurance carrier only upon the request of the DIA.

To clarify the usage of Form 154, it shall be completed by the insurance carrier of any out-of-state employer conducting business in Massachusetts at the request of the DIA's Office of Investigations. The DIA may also require an out-of-state business to submit this form at any time.

Use of this form shall commence immediately.

Sincerely,

Paul V. Buckley
Commissioner

FORM 154

The Commonwealth of Massachusetts

Department of Industrial Accidents
Office of Investigations - Dept. 154
1 Congress Street, Suite 100, Boston, Massachusetts 02114-2017
http://www.mass.gov/dia

DIA Use Only

VERIFICATION OF MASSACHUSETTS WORKERS' COMPENSATION COVERAGE FOR OUT OF STATE EMPLOYERS OPERATING IN MASSACHUSETTS

Massachusetts law mandates that all employers must provide workers' compensation insurance coverage for their employees. Out of state employers are required to provide Massachusetts workers' compensation coverage for all their employees working in Massachusetts. Employers whose existing workers' compensation insurance policies specifically list Massachusetts in section 3A of said policy's information page, satisfy this requirement.

Please note that employers whose workers' compensation insurance policies specifically list Massachusetts in section 3C regarding all states coverage (with or without certain state exclusions) shall provide verification from their insurance carrier that coverage is provided in Massachusetts. To satisfy this requirement, the insurance carrier must complete this form verifying that the employer meets all the mandatory requirements for indemnity workers' compensation insurance coverage for all employees engaged in the employer's Massachusetts operations. Upon request, this form, a copy of the policy's information page and a copy of any policy clause or clauses, which set forth conditions under which section 3C will become effective, must be submitted to the Office of Investigations of the Department of Industrial Accidents.

PLEASE NOTE THAT THIS FORM MUST BE COMPLETED BY THE INSURANCE CARRIER PROVIDING COVERAGE TO THE EMPLOYER.

INSURED'S INFORMATION

1. Legal Name and Address of the Insured (P.O. Box Not Acceptable):

_____

_____

_____

2. All Massachusetts Work Locations of Insured:

_____

_____

_____

3. Business Telephone Number of Insured:

_____

4. Federal Employer ID Number or Social Security Number of Insured:

_____

- Over -

INSURER'S INFORMATION

1. **Name of Insurance Carrier:**

_____

_____

2. **Name, Address and Telephone Number of Insurance Carrier Contact Person:**

_____

_____

_____

_____

_____

3. **Policy Number of Insured:**

_____

4. **Policy Term:**

_____

5. **List the name of the Proprietor, or all Partners or all Officers of the Insured and check the appropriate box below:**

_____

_____

_____

_____

_____

☐ **All individuals listed above are included in the coverage provided by the insurance carrier.**

☐ **Some of the above listed individuals are excluded from the coverage provided by the insurance carrier. These individuals are:**

_____

_____

_____

_____

This certifies that the insurance carrier listed above provides workers' compensation insurance coverage for its above-named insured's employees in Massachusetts. The information contained herein is true to the best of my knowledge and belief.

Signed under the pains and penalties of perjury.

Signature of Insurance Carrier Representative & Title **Print name** **Date**