The Commonwealth of Massachusetts
Department of Industrial Accidents/Office of Investigation
600 Washington Street
Boston, MA 02111

Workers' Compensation Insurance Affidavit: General Businesses

Applicant Information **Please Print Legibly**

Business/Organization Name:_____

Address:_____

City/State/Zip:_____Phone #:_____

Are you an employer? Check the appropriate box:

1.__ I am an employer with___employees (full and/ or part-time).*
2.__I am a sole proprietor or partnership and have no employees working for me in any capacity. (No workers' comp. insurance required)
3.__We are a corporation and its officers have exercised their right of exemption per c. 152 1(4), and we have no employees. (No workers'comp. insurance required)**
4.__We are a non-profit organization, staffed by volunteers with no employees. (No workers' comp. insurance req.)

Business Type (required):

5.__Retail
6.__Restaurant/Bar/Eating Establishment
7.__Office and/or Sales (incl. real estate, auto, auto, etc.)
8.__Non-profit
9.__Entertainment
10.__Manufacturing
11.__Health Care
12.__Other_____

*Any applicant that checks box #1 must also fill out the section below showing their workers' compensation policy information.
**If the corporate officers have exempted themselves, but the corporation has other employees a workers' compensation policy is required and such an organization should check box #1.

I am an employer that is providing workers' compensation insurance for my employees. Below is the policy information.

Insurance Company Name:_____

Insurer's Address:_____

City/State/Zip:_____

Policy # or Self-ins. Lic#_____Expiration Date:_____

Attach a copy of the workers' compensation policy declaration page (showing the policy number and expiration date).
Failure to secure coverage as required under Section 25A of MGL c. 152 can lead to the imposition of criminal penalties of a fine up to $1,500.00 and/or one-year imprisonment, as well as civil penalties in the form of a STOP WORK ORDER and a fine of up to $250.00 a day against the violator. Be advised that a copy of this statement may be forwarded to the Office of Investigations of the DIA for insurance coverage verification.

I do hereby certify, under the pains and penalties of perjury that the information provided above is true and correct.

Signature:_____Date:_____

Phone#:_____

Official use only. Do not write in this area, to be completed by city or town official.

City or Town: North Reading
Permit/License#_____

Issuing Authority : Board of Health

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Contact Person:_____Phone#:_____