The Commonwealth of Massachusetts
Department of Industrial Accidents
Office of Investigations
600 Washington Street
Boston, MA 02111
www.mass.gov/dia

Workers’ Compensation Insurance Affidavit: Builders/Contractors/Electricians/ Plumbers

Applicant Information
Please Print Legibly

Name (Business/Organization/Individual):

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. □ I am a homeowner doing all work myself. [No workers’ comp. insurance required.]
4. □ I am a general contractor and I have hired the sub-contractors listed on the attached sheet. These sub-contractors have workers’ comp. insurance.
5. □ We are a corporation and its officers have exercised their right of exemption per MGL c. 152, §1(4), and we have no employees. [No workers’ comp. insurance required.]

Type of project (required):
6. □ New construction
7. □ Remodeling
8. □ Demolition
9. □ Building addition
10. □ Electrical repairs or additions
11. □ Plumbing repairs or additions
12. □ Roof repairs
13. □ Other

*Any applicant who checks box #1 must also fill out the section below showing their workers’ compensation policy information.

I am an employer that is providing workers’ compensation insurance for my employees. Below is the policy and job site information.

Insurance Company Name:

Policy # or Self-ins. Lic. #: Expiration Date:

Job Site Address: City/State/Zip:

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: Permit/License #

Issuing Authority (circle one):

Contact Person: Phone #: