# 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 |
| 2008–2012 | 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



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Objective.Trusted.Integral.

1221 Broadway, Suite 900
Oakland, CA 94612

Voice 888.229.2472 customerservice@wcirb.com
Fax 415.778.7272 www.wcirb.com

# Coverage Research Service Request

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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 |
| **Physical Address** | **Physical Address** |
| Physical Address City | Physical Address City |
| Physical Address State Zip | Physical Address State Zip |
| **P.O Box Address** | **P.O. Box Address** |
| P.O Box City | P.O. Box City |
| P.O Box State Zip | P.O. Box State Zip |



WCIRB Customer Service 1221 Broadway, Suite 900 Oakland, CA 94612 Voice 888.229.2472 Fax 415.778.7272 customerservice@wcirb.com www.wcirb.com

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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.**



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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.

Authorized by **Authorized Signature Required**

Title Date

☐ Member Authorized TPE. (Member will be billed. Include member billing information below.)

Authorized by Signature

Title Date

Member Company

Address

City State Zip

### 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.



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