Coverage Research Service Request
Form 807 (Rev. 07/2009)

Instructions

Purpose of Form
Completion of this form is required for coverage requests made in connection with a pending workers' compensation claim.

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
2006–2007	2	$20
1/1/06–1/1/07	1	$10
1/1/06–1/31/07	2	$20
2006–3/1/09	4	$40
2005–2009	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.

Shipping
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
525 Market Street, Suite 800
San Francisco, CA 94105-2767

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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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 | 525 Market Street, Suite 800, San Francisco, CA 94105-2767 | Voice 888.229.2472 | Fax 415.778.7272 | customerservice@wcirbonline.org | www.wcirbonline.org

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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.

Restricted Use of Information

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.

$. _____

Payment Method — Members and TPEs

- ☐ WCIRB Member Billing.
- ☐ 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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