ILLINOIS WORKERS' COMPENSATION COMMISSION

REQUEST FOR INFORMATION ON EMPLOYER'S INSURANCE COVERAGE

If you cannot find any information regarding an employer's insurance coverage, please complete as much of this form as possible and send it to the Information Department, 100 W. Randolph St. #8-200, Chicago, IL 60601. We will not give your name to the employer. Please use a separate form for each employer.

_____
Today's Date

_____ _____ _____
Name of Business | Owner/Manager Name | Business telephone

_____ _____
Employer's Street Address, City, State, Zip | Employer's FEIN

_____ _____
Jobsite Street Address, City State, Zip (if different from above) | Number of Employees

_____ _____ _____
Injured Employee's Name | Date of Accident | WC Case #

_____ _____ _____
Your Name | Relationship to employee (if any) | Your Telephone #

_____ _____
Your Address, City, State, Zip | Your E-mail

A written response of insurance coverage or no coverage information will be forwarded to you.

For Office Use Only:

_____
_____
_____
_____
_____
_____