

WAIVER OF SUBROGATION WORKERS COMPENSATION REQUEST

PRODUCER NAME _____

INSURED
NAME: _____

POLICY # _____ Effective Date of Waiver: _____

CERTIFICATE HOLDER NAME & ADDRESS REQUESTING THE WAIVER:

CONTRACT OR PROJECT NUMBER: _____

CONTRACT OR PROJECTION LOCATION: (Please include street address and state)

JOB DESCRIPTION:

START/COMPLETION DATES: _____

PROJECTED LENGTH OF JOB: _____

Codes	Payrolls	#Employees(FT/PT)	Location

***PLEASE NOTE:**
ALL PAYROLL RECORDS FOR THE JOB CARRYING THE WAIVER MUST BE KEPT SEPARATELY FOR PREMIUM AUDIT PURPOSES.