30 S 17th Street, Suite 1500, Philadelphia, PA 19103 | 302.654.1435 | www.dcrb.com

DCRB
DELAWARE
Compensation Rating Bureau, Inc.

Dear Employer:

The Delaware Compensation Rating Bureau, Inc. (DCRB) is the workers' compensation rating authority for the State of Delaware referred to in your workers' compensation policy. As the rating authority, the DCRB maintains proof-of-coverage records for the state and is authorized by Delaware State Law to obtain all pertinent information regarding your workers' compensation insurance.

Title 19, Part II, Chapter 23, Workers' Compensation, § 2372 of the Delaware Insurance Code mandates all Delaware employers insure their workers' compensation liability in some corporation, association or organization approved by the Department of Insurance and authorized to transact the business of workers' compensation insurance in state of Delaware; unless specifically exempted.

The DCRB's records currently do not reflect an active workers' compensation insurance policy for your company. It is necessary for you or your insurance agent to answer and return the attached confidential coverage questionnaire within the next two (2) weeks to confirm your current coverage. The questionnaire (QNCC-DE) may also be completed online at www.dcrb.com under the FORMS section of our website and submitted via email to coverage@dcrb.com.

Regardless of the option chosen, failure to return the form with the requested coverage information and/or the failure to continuously maintain workers' compensation coverage may result in an investigation by the Delaware Industrial Accident Board.

Thank you in advance for your cooperation in completing the DCRB's record.

Employer Coverage

Extension – 4424

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DCRB DELAWARE
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BUREAU INFORMATION QUESTIONNAIRE

FILE NO._____

1. The following NAME(S) and LOCATION(S) appear on your policy. (Make necessary corrections)

F.E.I.N. # _____

2. Does your Company operate under any other name? ☐ Yes ☐ No If yes, give Company Name.

_____

3. According to this bureau's records your Workmen's Compensation Insurance expired on _____

   We have no record of coverage since your last coverage shown on original application. Policy.

   Policy Number _____ Effective Date _____ Expiring _____

   (Canceled _____)

4. Please indicate the Insurance company, Policy Number and Effective Date of all Workmen's Compensation Insurance Policies from _____ to present.

INSURANCE COMPANY _____

Policy Number _____ Effective Date _____

INSURANCE COMPANY _____

Policy Number _____ Effective Date _____

5. Please answer the following questions concerning your Company's present status.

Yes	No	
☐	☐	Is your Company operating with employees?
☐	☐	Is your Company operating without employees?
☐	☐	Is your company out of business? If yes, what date did it cease operations in DE? (Month/Day/Year) _____
☐	☐	Was your company sold to another concern? If yes, what is the new concern's name? _____ What date did the ownership change take place? (Month/Day/Year) _____ How many employees were retained by this new concern? _____ out of _____ or _____ % retained.

6. Your Company's Phone Number - Area Code (_____) _____

7. Questionnaire completed by (Your Name) _____ Title _____

8. Your Agents Name and Telephone Number. (Name) _____

   (Telephone Number) Area Code (_____) _____

FORM MAY BE COMPLETED BY AGENT

(PLEASE USE OTHER SIDE FOR ANY ADDITIONAL EXPLANATIONS)