30 S 17th Street, Suite 1500, Philadelphia, PA 19103 | 215.568.2371 | www.pcrb.com

Dear Employer:

The Pennsylvania Compensation Rating Bureau (PCRB) is the workers' compensation rating authority for the Commonwealth of Pennsylvania referenced in your workers' compensation policy. As the rating authority, the PCRB maintains proof-of-coverage records for the commonwealth and is authorized by the Pennsylvania Insurance Company Law of 1921, P.L. 682 and Act 44 of 1993, to obtain all pertinent information regarding your workers' compensation insurance.

Section 305 of the Pennsylvania Workers' Compensation Act, 77 P.S. 501 mandates all Pennsylvania employers insure their workers' compensation liability with any insurance company, mutual association or company authorized to insure such liability in Pennsylvania; unless specifically exempted.

The PCRB'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-PA) may also be completed online at www.pcrb.com under the FORMS section of our website and submitted via email to coverage@pcrb.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 Pennsylvania Bureau of Workers' Compensation's Compliance Section.

Thank you in advance for your cooperation in updating the PCRB's records.

POLICY COVERAGE UNIT
EXTENSION 4424

30 S 17th Street, Suite 1500, Philadelphia, PA 19103 | 215.568.2371 | www.pcrb.com

PENNSYLVANIA
Compensation Rating Bureau

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 Workers Compensation Insurance expired on ____________________

We have no record of coverage since your ____Policy.

Policy Number ____________________ Effective Date ______________ Expiring ____________

(Canceled ____________)

4. Please indicate the Insurance Company, Policy Number and Effective Date of all Workers 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 PA? (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) ______________________________

9. Completion Date ____________________ (Telephone Number) Area Code (____) ______________

FORM MAY BE COMPLETED BY AGENT