



The Commonwealth of Massachusetts  
 Department of Industrial Accidents  
 1 Congress Street, Suite 100  
 Boston, MA 02114-2017  
 www.mass.gov/dia

Workers' Compensation Insurance Affidavit: Builders/Contractors/Electricians/Plumbers.  
 TO BE FILED WITH THE PERMITTING AUTHORITY.

**Applicant Information**

Name (Business/Organizational/Individual): \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone #: \_\_\_\_\_

Are you an employer? Check the appropriate box:	Type of project (required):
1. I am an employer with _____ employees (full and/or part time)*	7. New construction
2. I am a sole proprietor or partnership and have no employees working for me in any capacity. [No workers' comp. insurance required.]	8. Remodeling
3. I am a homeowner doing all work myself. [No workers' comp. insurance required]†	9. Demolition
4. I am a homeowner and will be hiring contractors to conduct all work on my property. I will ensure that all contractors either have workers' compensation insurance or are sole proprietors with no employees.	10. Building addition
5. I am a general contractor and I have hired the sub-contractors listed on the attached sheet. These sub-contractors have employees and have workers' comp. insurance.‡	11. Electrical repairs or additions
6. We are a corporation and its officers have exercised their right of exemption per MGL. c. 152, §1(4), and we have no employees. [No workers' comp. insurance required.]	12. Plumbing repairs or additions
	13. Roof Repairs
	14. Other

\*Any applicant that checks box #1 must also fill out the section below showing their workers' compensation policy information.

†Homeowners who submit this affidavit indicating they are doing all work and then hire outside contractors must submit a new affidavit indicating such.

‡Contractors that check this box must attach an additional sheet showing the name of the sub-contractors and state whether or not those entities have employees. If the sub-contractors have employees, they must provide their workers' comp. policy number.

**I am an employer that is providing workers' compensation insurance for my employees. Below is the policy and job site information.**

Insurance Company Name: \_\_\_\_\_

Policy # or Self-ins. Lic. #: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Job Site Address: \_\_\_\_\_

**Attach a copy of the workers' compensation policy declaration page (showing the policy number and expiration date).**

Failure to secure coverage as required under MGL. c. 152, §25A is a criminal violation punishable by a fine up to \$1,500.00 and/or one-year imprisonment, as well as civil penalties in the form of a STOP WORK ORDER and a fine of up to \$250.00 a day against the violator. A copy of this statement may be forwarded to the Office of Investigations of the DIA for insurance coverage verification.

**I do hereby certify under the pains and penalties of perjury that the information provided above is true and correct, and that clicking this checkbox and typing my name in the field below will act as my signature.**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Phone #: \_\_\_\_\_ Email: \_\_\_\_\_