Workers' Compensation Administration

EDI Proof of Coverage Insurer Information

This form is used to provide information on Insurers submitting POC data via Electronic Data Interchange. Each entry on this form must correspond to an entry on an E7 Sender/Vendor form. Up to three insurers may be listed on this form. Attach additional E8 forms if necessary..

Please type or print clearly:

Sender/Vendor Name: ________________________________ Sender/Vendor FEIN: __________

Contact Person: ________________________________

Contact's Phone Number: __________ Contact's E-mail: ________________________________

Insurer Information:

Insurer (Carrier) Name: ________________________________ Insurer FEIN: __________

Mailing Address: ________________________________

City: __________________ State: __________ Zip Code: __________

Contact Person: ________________________________

Contact's Phone Number: __________ Contact's E-mail: ________________________________

Responsible Party Name: ________________________________ **Date:** __________

Insurer Information:

Insurer (Carrier) Name: ________________________________ Insurer FEIN: __________

Mailing Address: ________________________________

City: __________________ State: __________ Zip Code: __________

Contact Person: ________________________________

Contact's Phone Number: __________ Contact's E-mail: ________________________________

Responsible Party Name: ________________________________ **Date:** __________

Insurer Information:

Insurer (Carrier) Name: ________________________________ Insurer FEIN: __________

Mailing Address: ________________________________

City: __________________ State: __________ Zip Code: __________

Contact Person: ________________________________

Contact's Phone Number: __________ Contact's E-mail: ________________________________

Responsible Party Name: ________________________________ **Date:** __________