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:** __________