STATE OF IDAHO CERTIFICATE OF VERIFICATION

**OF WORKERS' COMPENSATION INSURANCE**

Read thoroughly before completing form.

***WHAT ARE THE WORKERS’ COMPENSATION REQUIREMENTS?***

The Idaho Workers' Compensation Law requires that employers who hire one or more, either full or part-time employees, to perform work in the State of Idaho, carry workers' compensation insurance unless specifically exempted. ***Failure to comply could result in monetary penalties as well as an injunction to prohibit the employer from operating the business. Failure to carry workers’ compensation insurance for employees is a misdemeanor under Idaho Law.***

***WHO MUST COMPLETE THIS FORM?***

Any person, partnership, limited liability company, corporation or firm who is bidding on a contract for the United States Department of Agriculture/Forest Service (USFS) for work that is within the State of Idaho and who has been notified by the USFS that he/she/it has been selected for a USFS contract.

***WHEN MUST THE FORM BE COMPLETED?***

The form must be completed and forwarded to one of the Industrial Commission offices when you are notified by the USFS that you have been selected for a USFS contract. The approval of the Industrial Commission is required prior to the final award.

***ADDITIONAL COMMENTS:***

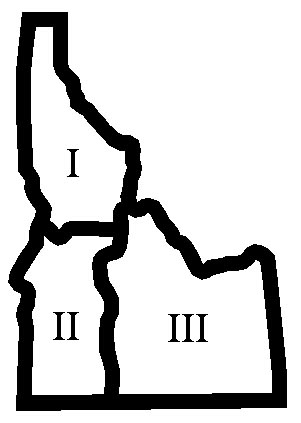
Failure to complete any part of the form that is applicable to your operations could result in a delay in processing.

If any of the work is to be performed by sub-contractors, each sub-contractor must obtain and complete a Certificate of Verification of Workers' Compensation insurance.

If your business is a partnership, limited liability company or corporation, each partner/member/corporate officer must sign the form where designated.

You must submit a separate verification form for each contract awarded.

***ONCE THE BIDDER HAS COMPLETED AND SIGNED THE FORM, FAX, MAIL, OR DELIVER IT TO* *THE APPROPRIATE INDUSTRIAL COMMISSION OFFICE. IF YOU HAVE ANY QUESTIONS,* *CONTACT A COMPLIANCE REPRESENTATIVE AT ANY OF THE FOLLOWING OFFICES:***



***North Idaho***

1221 Ironwood Street, Suite 100

COEUR D'ALENE ID 83814

(208) 769-1565 or FAX (208) 769-1465

***Southwest Idaho***

**317 Main Street**

**P 0 BOX 83720, BOISE ID 83720-0041**

**(208) 334-6032 or 1-800-950-2110**

**or FAX (208) 334-5145**

***Southeast Idaho***

1070 Hiline, Suite 300

POCATELLO ID 83201

(208) 236-6366 or FAX (208) 236-6040

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| **FOR I.C. USE ONLY**  **IC#**  **Received** |

**STATE OF IDAHO**

**CERTIFICATE OF VERIFICATION**

**OF WORKERS' COMPENSATION INSURANCE**

**Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| 1. Contractor’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 2. Business Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 3. Contractor’s Federal Identification Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 4. Contactor’s Business Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Street, Box # City, State Zip |
| 5. Contractor’s Business Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 6. Contractor’s Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Street, Box # City, State Zip |
| 7. Name of Supervisor in charge of project: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 8. Supervisor’s Business Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Street, Box # City, State Zip |
| 9. Supervisor’s Business Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 10. Supervisor’s Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Street, Box # City, State Zip |
| 11. **Classification of Business** |

(a) Corporation (List names, addresses & telephone numbers of corporate officers and directors, and percent of ownership.)

(b) Partnership/Limited Liability Company (List partner/member names, addresses & telephone numbers, and percent of ownership.)

(c) Sole Proprietorship

(d) Other – Please explain

**Description of Project: Solicitation #:**

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| 12. Contract #: Estimated Start Date: |
| 13. Location of Work: **in the vicinity of Elk City, Idaho** |
| 14. Description of Work: **Fivemile Culvert Replacement** |
| 15. Office Overseeing Contract: |

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| 16. **DO YOU HAVE WORKERS’ COMPENSATION INSURANCE?** Yes No |
| 17. Workers’ Compensation Insurance Company  Name of Carrier: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Policy # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Effective Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Name of Agent \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel. # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Street, Box City, State Zip  Extraterritorial Coverage # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Approved \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiration Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 18. If Contractor is a **sole proprietorship/partnership/limited liability company,** will workers other than the  proprietor or partners/members be performing any of the work to be done under this contract?  Yes No  **If yes,** state the approximate number of such workers and, if known, their names, permanent addresses,  telephone numbers, and date of hire. (Attach additional pages, if needed.) |
| 19. If Contractor is a **corporation,** will workers who are not officers and 10% shareholders and directors  of the corporation be performing any of the work to be done under this contract?  Yes No  **If yes,** state the approximate number of such workers and, if known, their names, permanent addresses,  Telephone numbers, and date of hire. (Attach additional pages, if needed.) |
| 20. Do you intend to use any sub-contractors to assist you in the performance of this contract?  **Note: All sub-contractors used on this contract must also submit a Certificate of Verification**  **of Workers’ Compensation Insurance for approval prior to commencing work in this contract.**  Yes No  **If yes,** state their names, business names, permanent addresses and telephone numbers. |
| 21. Based upon my knowledge of the work to be performed under the contract specified on page 1 and upon my  knowledge of work practices, methods and technologies to be applied during this contract, I estimate that  workers are necessary to do the work in the time prescribed, assuming average production rates and conditions. |

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| ***22. I certify that the above information is true and correct to the best of may knowledge and belief.***  Further, I agree to inform the Industrial Commission Compliance Officer if there is any change in the above  Information during the time this contract is in effect.  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Type or Print Contractor’s Name  By:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| 23. If the business is a partnership, limited liability company or corporation, this document requires  the signature of **all** of the partners/members/corporate officers. (Attach additional pages if necessary.)  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Partner/member/Corp. Off. Title % of Ownership  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Partner/member/Corp. Off. Title % of Ownership  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Partner/member/Corp. Off. Title % of Ownership  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Partner/member/Corp. Off. Title % of Ownership |

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CONTRACTOR – DO NOT WRITE BELOW THIS LINE

***Based solely upon the assertions above set forth, and without warranty of continued compliance, the Idaho Industrial Commission finds that Contractor:***

Currently carries workers’ compensation insurance as required by state law.

Has a current extraterritorial on file from the State of which covers

only based employees while working temporarily in the State of Idaho.

Extraterritorial coverage expires .

Is not required to provide workers’ compensation insurance because:

Is a partnership/limited liability company/sole proprietor which employs no workers other than the partners/members/sole proprietor and will not employ any other workers under this contract.

Is a corporation which employs no workers other than individuals who are corporate officers, directors and 10% shareholders and will not employ any other workers under this contract.

Other (Specify):

(By making the above finding, the Commission does not warrant continued compliance.)

Has not obtained the required workers’ compensation insurance.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Industrial Commission Compliance Officer

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contract/Solicitation#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_