WCIRB Coverage Website Dispute Form

Form 602 (Rev. **12**/202**1**)

Instructions

Purpose of Form

This form is used to file a dispute with the WCIRB regarding the accuracy of information displayed on caworkcompcoverage.com. Employer, as used in this form, means the person or entity that is a named insured on the workers' compensation policy for which a query regarding coverage is being made.

Use of Form

This form must be completed by the employer, or an authorized representative designated by the employer. The agent or broker of record for the employer must submit a copy of the Broker of Record letter with the form. The employer's attorney must identify themself as the attorney for the employer. All others must submit a Coverage Website Letter of Authorization signed by the policyholder.

Review and Response to Dispute

A response may take up to 30 days. As necessary, the WCIRB will use the information submitted on this form to contact the insurer and verify the accuracy of the coverage reported.

Form Submission Requirements

Please complete all information requested on the form

- If you need additional information or assistance with the form, please call WCIRB Contact Center
- Please submit a copy of the policy, policy declaration page or a certificate of insurance as supporting documentation
- **Incomplete information will result in a delay as forms will be returned for completion**

Form **Complet**ion

This form can be completed electronically, printed or typed, and emailed or mailed to the following:

EMAIL caworkcompcoverage@wcirb.com

MAIL WCIRB California
Attn: Contact Center
1901 Harrison Street, 17th Floor
Oakland, CA 94612

If you have questions about this form, contact the WCIRB Contact Center toll free at **888.271.7615.**

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Please note: This form is to be used solely to notify the WCIRB of a potential error on caworkcompcoverage.com. The website will be updated only if the insurer of record submits a copy of the workers' compensation policy directly to the WCIRB. The WCIRB is unable to accept a policy from any other source.

Contact Information

This form must be completed by the employer or the employer's authorized representative. The WCIRB will not accept Coverage Website Dispute Forms submitted by any other party.

Name | Date

Company Name

Address | City | State | Zip

Telephone Number | Fax Number

Email Address

- ☐ I am the Policyholder
- ☐ I am an attorney for the Policyholder
- ☐ I am the agent or broker of record for the Policyholder. (Please attach a copy of the Broker of Record letter.)
- ☐ Other (A Coverage Website Letter of Authorization is required.)

Please provide a detailed description of the coverage information you believe to be missing or inaccurate.
Please include a copy of the workers' compensation insurance policy, policy declaration page or a certificate of insurance as supporting documentation.

Policy Information

Please provide details regarding the policy information that you believe is inaccurate or not appearing on the website.

Named Insured(s) on Policy

Policyholder Address | City | State | Zip

Insurer Name | Policy Number | Policy Effective Dates

Name of Contact at Insurer | Phone Number | E-mail Address

Please attach copies of any correspondence between you and your insurance company concerning this dispute.

Workers' Compensation Insurance Rating Bureau of California
1901 Harrison Street, 17th Floor
Oakland, CA 94612
Voice 888.271.7615
Fax 415.778.7272
caworkcompcoverage@wcirb.com
www.wcirb.com

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Coverage Website Letter of Authorization

Incomplete forms may result in a delay or a failure to process the request.

This form is to be completed by the named Policyholder; if the Policyholder is a company, it must be completed by a principal of the company or other entity.

I, _____ , am the Policyholder or am the _____
Name of Policyholder — Title — Must Be a Principal of Policyholder Company

of _____
Policyholder's Company Name

located at _____ _____ _____ _____
Street Address — No P.O. Boxes — City — State — Zip

I hereby authorize _____
Name

of _____
Company Name

located at _____ _____ _____ _____
Address — City — State — Zip

to act on my behalf with respect to issues involving the WCIRB Coverage Website Dispute Form.

This Coverage Website Letter of Authorization is valid only for this specific request.

_____ hereby agrees to indemnify and hold the WCIRB harmless from and against
Name of Policyholder

any claim against the WCIRB related to the WCIRB's provision of any information provided as a result of signing this Coverage Website Letter of Authorization.

I warrant and represent that I am authorized to act for and bind _____
Policyholder's Company Name

for purposes of executing this Coverage Website Letter of Authorization.

The foregoing is executed under penalty of perjury under the laws of the State of California

this day, _____ , of _____ _____
Date — Month — Year

at _____, _____.
City — State

_____ _____
Authorizing Signature for Policyholder — Printed Name

Workers' Compensation Insurance Rating Bureau of California
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