SERVICE CENTER

APPLICATION FOR WAIVER OF SUBROGATION

DATE:
INSURED:
POLICY NUMBER:

Complete name and address of the certificate holder:

_____

_____

Is this the same address as the job location? If not, please list the address of the job location:

_____

Please include the below information:

Please provide a description of the job requiring the waiver. _____

What is the total payroll of the job requiring the waiver? _____

Is the payroll already accounted for on the policy? _____

Which location should this payroll be moved from? _____

What is the relationship of the third party to the insured? _____

All questions must be answered. Failure to do so will delay our underwriting review of your request for a Waiver of Subrogation. Completion of this form does not guarantee approval. Approval time will be 48-72 hours following our receipt of all required information.

Please sign: _____

Please return to Colleen Lahna at clahna@massagent.com or by fax to 508-634-2930.