



# WORKERS COMPENSATION WAIVER OF SUBROGATION REQUEST FORM

Insured Name: \_\_\_\_\_ Policy #: \_\_\_\_\_

Name and Address of 3rd party from whom the Waiver of subrogation is being requested:

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Specific details of the Job:

Job number: \_\_\_\_\_ State Date: \_\_\_\_\_ End Date: \_\_\_\_\_

Please list specific operations that will be performed:

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Please explain the scope of the project:

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Specific Location of the job - Street address, city or area, state:

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Total payroll for the specific job being performed or total payroll for ongoing jobs: \$ \_\_\_\_\_

Number of Employees involved: \_\_\_\_\_

Who is responsible for safety controls on this project? What controls are in place?

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