Department of Commerce

WORKERS' COMPENSATION COMMISSION
COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS
P.O. Box 5795 CHRB, Saipan MP 96950
Tel: (670) 664-8018/8024 • Fax (670) 664-8074

This Certificate of Compliance is hereby filed in accordance with Section 9346 of Public Law 6-33.

PART1. EMPLOYER'S INFORMATION

NAME OF EMPLOYER: _____

OTHER NAME OR DOING BUSINESS AS (DBA): _____

MAILING ADDRESS: _____

TELEPHONE NUMBER(S): _____

TYPE OF BUSINESS: ( ) SOLE PROPRIETOR ( ) CORPORATION ( ) PARTNERSHIP
( ) ASSOCIATION ( ) OTHERS _____

DATE OF HIRED OR ARRIVAL IN THE CNMI: _____ (ATTACHED PROOF)

DRAW AREA MAP IN THE BACK (LOCATION OF YOUR BUSINESS)

PART II. INSURANCE COVERAGE

CHECK ONE BOX BELOW TO DESCRIBE THE STATUS OF YOUR INSURANCE COVERAGE:

( ) NEW ( ) RENEWAL ( ) SWITCHED CARRIER

NAME OF INSURANCE CARRIER: _____

NO. OF EMPLOYEES COVERED: _____ ESTIMATED PREMIUM: $ _____

EFFECTIVE DATE OF POLICY: _____ EXPIRATION OF POLICY: _____

PLEASE ATTACHED INSURANCE POLICY

Declaration: I hereby, declare under penalty of perjury that the information contained in this Certificate of Compliance is true and correct to the best of my knowledge. I also understand that I am responsible to file this Notice of Compliance within 30 days each year upon renewal of my insurance coverage.

_____ _____ _____

Name and Title Signature Date