CareWorks

State of Washington Enrollment Form

Department of Labor and Industries
Retrospective Rating
P.O. Box 44180
Olympia, WA 98504-4180

DATE: _____

Please release all historical workers' compensation claims and premium data to CareWorks Comp and its representatives for the following company:

FIRM NAME: _____

ACCOUNT ID: _____

This authorization includes access to the Claim and Account Center (CAC) to review all premium paid, hours reported, and claims charged to the account(s). This release expires six (6) months after date signed.

Thank you for your assistance.

Sincerely,

NAME (PRINT): _____

SIGNATURE: _____

TITLE: _____

PHONE: _____ **EMAIL:** _____

Please fax this letter to 888.837.3288 or email it to **INFO@CAREWORKSCOMP.COM**