EL-2
4/1/97

# LESSEE INFORMATION FORM

## INSTRUCTIONS

This information page must be completed for every Kentucky Lessee whose workers' compensation insurance coverage for leased employees, as required by KRS342.340 and KRS 342.640, is provided by an insurance policy in the name of the Employee Leasing Company or related entity. The completed form(s) must be filed within ninety (90) days of initial registration of the Employee Leasing Company and updated every six (6) months. Filing shall be perfected upon receipt at the following address: Department of Workers' Claims, Attention: Compliance Branch, 657 Chamberlin Ave., Frankfort, KY 40601.

1. Employee Leasing Company Name: ______________________________

Contact Name: ______________________ Phone No.: ______________

Email Address: ______________________ Fax No.: ______________

2. Lessee Name: ______________________________

3. DBA: ______________________________

4. Principal Address: ______________________________
(Address Line 1)
______________________________
(Address Line 2)
______________________________
(City, State, Zip)

5. KY Address (if applicable): ______________________________
(Address Line 1)
______________________________
(Address Line 2)
______________________________
(City, State, Zip)

Contact Name: ______________________ Phone No.: ______________

Email Address: ______________________ Fax No.: ______________

6. FEIN or SSN: ______________________

7. Type of Entity: ______________________________
(Proprietorship, Partnership, Corporation)

8. Effective date of workers' compensation coverage under employee leasing company: ______________

Policy No: ______________________ Issued by: ______________________

9. Termination of coverage date: ______________________