encova INSURANCE

REQUEST FOR FILE COPIES

Return completed form to:
Encova Insurance
P.O. Box 3151
Charleston, WV 25332-3151
Or fax to: 877-898-6980

REQUESTER MUST COMPLETE THESE SPACES

Requester name
Address
City, state, ZIP
Telephone number
Date of request
Injured worker or employer name
Claim or policy number
Injured worker date of injury
Injured worker Social Security number
Injured worker date of birth

Check type requested ☐ CD ☐ Paper

If you are not being provided with appropriate copies, please contact your claims adjuster.

A separate form must be used for EACH file requested. An authorization (release) must be attached if requester is someone other than the claimant or employer.

PRINT, SIGN AND DATE THE APPROPRIATE BOX

Employer	
Print	
Signature	Date
Claimant	
Print	
Signature	Date
Attorney	
Print	
Signature	Date
Other (please specify)	
Print	
Signature	Date