## COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT DIVISION OF WORKERS' COMPENSATION

# REJECTION OF COVERAGE BY CORPORATE OFFICERS OR MEMBERS OF A LIMITED LIABILITY COMPANY (LLC)

#### PART A

2. Name of Corporation or LLC  3. Mailing Address  Street or P.O. Box, Unit/Suite  City  State  Zip  4. Nature of Business  5. Federal Employer Identification Number  6. Business Phone  7. Date of Incorporation or Organization  8. State of Incorporation or Organization  9. Corporate Officers or LLC Members Rejecting Coverage:  Name  First  Middle  Last  Suffix (Jr., Sr., III)  Title(s)  Ownership/ Member Inters  10. Number of employees of the business ather than the officers or members listed above:  11A. Does your company have workers' compensation insurance? Yes No  11B. If you answered "Yes" to Question 11A, please include your workers' compensation policy information below and submit this completed form directly to your carrier. If you answered "No" to Question 11A, please submit this completed form directly to the Colorado Division of Workers' Compensation.  a. Insurance carrier name  b. Policy Number  c. Effective Dates  From  To  12. Certification:  I,  Name of Corporate Secretary or LLC Manager  name of Corporate Secretary or LLC Manager  Rame of Corporation or LLC  Name of Corporation or LLC  Name of Corporation or LLC	1. Type of Entity	Corporation	Limited 1	Liability Company (LLC	)			
Street or P.O. Box, Unit/Suite  City State Zip  4. Nature of Business  5. Federal Employer Identification Number	2. Name of Corpora	ation or LLC						
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5. Federal Employer Identification Number				City		State	Zip	
7. Date of Incorporation or Organization	4. Nature of Busine	ess						
9. Corporate Officers or LLC Members Rejecting Coverage:    Name	5. Federal Employe	er Identification N	umber	6. B	usiness Phone			
Name   Last   Suffix (Jr., Sr., III)   Title(s)   Number of Ownership/Member Interests	7. Date of Incorpor	ation or Organiza	tion	8. State of Ir	acorporation or	· Organiza	ition	
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<ul> <li>11B. If you answered "Yes" to Question 11A, please include your workers' compensation policy information below and submit this completed form directly to your carrier. If you answered "No" to Question 11A, please submit this completed form directly to the Colorado Division of Workers' Compensation.  a. Insurance carrier name</li></ul>	•	2				e:		
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c. Effective Dates From To	below and sul	bmit this complete	ed form direc	ctly to your carrier. If you	answered "No	o" to Que	stion 11A,	
I,	a. Insurance	carrier name	_	b. Pc	olicy Number .			
I,, in my capacity as Corporate Secretary or LLC Manager of Name of Corporate Secretary or LLC Manager, certify that the above and attached information is correct and complete.	c. Effective I	Dates From		To				
Name of Corporate Secretary or LLC Manager	12. Certification:							
, certify that the above and attached information is correct and comple	I,			_, in my capacity as Corp	orate Secretar	y or LLC	Manager of	
	Name of Co	orporate Secretary or	LLC Manager			•	C	
	Name of C	orporation or LLC	, certify th	nat the above and attached	d information i	s correct	and complete.	
Signature of Corporate Secretary or LLC Manager Date		Si	gnature of Corp	porate Secretary or LLC Mana	nger		Date	

C.R.S. Section 10-1-128(6)(a) states: "It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies."

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## COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT DIVISION OF WORKERS' COMPENSATION

# REJECTION OF COVERAGE BY CORPORATE OFFICERS OR MEMBERS OF A LIMITED LIABILITY COMPANY (LLC)

PART B - Corporate Officer or LLC Member Questionnaire IMPORTANT: A separate Part B <u>MUST</u> be completed by <u>every</u> person listed in Part A.

1. Name of Corporation or LLC							
2. Mailing Address							
		Street or P.O. Box, Unit/Suite					
		City	State	Zip			
3. Officer or Member Name	First	Middle	Last	Suffix (Jr., Sr., III)			
4. Corporate Officer Title			s Phone				
6. Date Officer/Member Elected							
7. Duties performed for Corporation							
8. Mark ONE that Applies:							
By signing this form, you are ac Act and that if you are hurt on acknowledging that you are an membership interest of the LLC or LLC. The election to reject voluntary and cannot be a cond I hereby rescind my previous	the job, C.R.S. § 8- owner of at least 10 C at all times, and o vorkers' compensa ition of your empl	41-401(3) may limit your red 0% of the stock of the corporation insurance as a corporation insurance.	covery to \$15,000. Y ration or at least 10° the business affairs	You are further  Who of the  of the corporation			
Corporate Office		Date					
9. <b>Notary:</b> If this form is being filed individual corporate officer or LLC with your insurance carrier, please c be notarized.	member comple ontact your insu	ting Part B must be notar rance carrier to determine	ized. If this form it	is being filed			
Subscribed and sworn to me before	this c	lay of	<del>,</del>	•			
		Notary	Public				
SEAL		In and for	Cou	nty			
		and	S1	tate.			
		My commission expires					

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#### **INSTRUCTIONS/DEFINITIONS**

General Instructions: Complete all information. Type or legibly print. A separate questionnaire, Part B, must be completed and attached for each officer/member rejecting coverage. Incomplete forms may not be processed and may be returned. Mail the forms by certified mail to the insurance carrier or the Division of Workers' Compensation per the below mailing instructions.

The effective date of election is the day following receipt of said notice by the insurance carrier or the Division. If an officer or limited liability company member changes his/her election, a revised questionnaire must be filed.

### Part A

- 1. **Type of Entity:** Check the appropriate box to indicate if the company is a corporation or a limited liability company (LLC).
- **2.** Name of Corporation or LLC: List the legal name of the corporation or LLC as filed with the Secretary of State.
- **3. Mailing Address:** List the complete business mailing address of the corporation or LLC including Street or P.O. Box, Suite Number, City, State, and Zip Code.
- **4. Nature of Business:** Briefly describe the type and nature of business conducted by the corporation or LLC.
- **5. Federal Employer Identification Number:** List the 9-digit Federal Employer Identification Number assigned to the corporation or LLC by the Internal Revenue Service.
- **6. Business Phone:** List the telephone number of the Corporate Secretary or LLC Manager signing Part A of the form.
- **7. Date of Incorporation or Organization:** List the date of incorporation for a corporation or the date of filing of Articles of Organization for an LLC.
- **8. State of Incorporation or Organization:** List the state where the corporation is incorporated or where the LLC filed its Articles of Organization.
- 9. Corporate Officers or LLC Members Rejecting Coverage: List the full name of the person(s) rejecting coverage. Please include first, middle, last, and suffix (if applicable). Include title or titles, and the percent of corporate ownership or membership interest in the company for each corporate officer or LLC member electing to reject workers' compensation coverage. Under C.R.S. §8-41-202(4), "corporate officer" means "the chairperson of the board, president, vice-president, secretary, or treasurer who is an owner of at least ten percent of the stock of the corporation and who controls, supervises or manages the business affairs of the corporation, as attested to by the secretary of the corporation at the time of the election." Corporate officers and LLC members must own at least 10% of the membership interest in the company at all times and control, supervise or manage the business affairs of the limited liability company to be eligible to reject coverage. Attach separate sheet if more space is needed.
- 10. Number of employees of the corporation or LLC other than officers or members listed above: List the number of employees other than officers or members listed under #9. Any person who is an employee of the corporation or LLC, who is not a corporate officer or LLC member electing to reject coverage, must be insured for workers' compensation.
- 11A. Does your company have workers' compensation insurance? Place a check in the appropriate space indicating whether the business has Workers' Compensation insurance.
- **11B.** If "Yes" to Question 11A, provide Workers' Compensation insurance policy information: If your business has Workers' Compensation insurance, list the name of the insurance carrier, the complete current policy number, and the effective dates of the current policy.
- **12. Certification:** Only the Corporate Secretary or LLC Manager shall sign and date Part A certifying that the information contained on the form is correct and complete. If a Corporate Secretary has not been named, the President may sign in lieu of the Corporate Secretary. Type or legibly write the name of the Corporate Secretary or LLC Manager and the name of the corporation or LLC.

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### Part B, Corporate Officer or LLC Member Questionnaire

To be completed by <u>each</u> Officer or Member electing to reject workers' compensation insurance coverage or rescinding a previous election.

- 1. Name of Corporation or LLC: List the legal name of the corporation or LLC as filed with the Secretary of State.
- **2. Mailing Address:** List the complete business mailing address of the corporation or LLC including Street or P.O. Box, Suite Number, City, State, and Zip Code.
- 3. Officer or Member Name: List the name of the individual corporate officer or LLC member completing Part B. List the full name of the person rejecting coverage. Please include first, middle, last, and suffix (if applicable).
- **4. Corporate Officer Title:** List the title of the individual corporate officer completing Part B. If an LLC member is completing Part B, leave blank.
- **5. Business Phone:** List the business telephone number of the individual corporate officer or LLC member completing Part B.
- **6. Date Officer/Member Elected:** List the date the individual corporate officer or LLC member completing Part B was elected to the position.
- 7. **Duties performed for Corporation or LLC:** Briefly describe the specific duties performed for the corporation or LLC by the individual corporate officer or LLC member completing Part B.
- **8. Mark ONE that Applies:** Check the appropriate box to indicate if the individual corporate officer or LLC member completing Part B is rejecting worker's compensation coverage or rescinding a previously filed rejection of coverage. The individual rejecting coverage or rescinding coverage must sign and date Part B. If the rescinding option is selected, Part A need not be completed.
- **9. Notary:** If this form is being filed with the Division of Workers' Compensation, the signature of the individual corporate officer or LLC member completing Part B must be notarized. If this form is being filed with your insurance carrier, please contact your insurance carrier to determine if they require this form to be notarized.
- **10.** Copy of form: You may wish to keep a copy of all forms for your records before submitting the original forms.

### **Mailing Instructions**

<u>Insured</u>: If the corporation or LLC <u>has</u> a workers' compensation insurance carrier, file this form by certified mail directly with your insurance carrier.

<u>Noninsured</u>: If there is <u>no</u> workers' compensation insurance carrier, file this form by certified mail with the Division of Workers' Compensation at the following address:

Division of Workers' Compensation Coverage Enforcement Unit 633 17th St., Suite 400 Denver, CO 80202-3626 303.318.8700

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