

# Instructions for Completing the REJECTION OF COVERAGE BY PARTNERS AND SOLE PROPRIETORS PERFORMING CONSTRUCTION WORK ON CONSTRUCTION SITES

Please read all pages

This form is “**fillable**.” That means you can type the information onto the form from your computer and print the form. You will not be able to save the form onto your computer’s hard drive.

When you open the form, click in the appropriate check box (field), and use the tab key to navigate to the next field. To fill in a **check box**, click inside the box with your mouse. Do not use the Enter key; pressing the Enter key will only page down. Each field has been *limited*. This means that you cannot continue to type information into a field if it doesn’t fit into the space provided.

Use numbers only to fill in the fields for Social Security # and Business Phone. Do not use dashes or parentheses; when you tab out of the field, it will fill in automatically.

To clear or delete all the information you have typed onto the form, click on the red “**Clear Entire Form**” button. To clear all information on a single page, click on the red “**Clear This Page**” button. To change the information in a single field, use the backspace or delete key.

Adobe Acrobat - [WC043 Rejection of Coverage.pdf]

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COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT  
DIVISION OF WORKERS' COMPENSATION

**Clear Entire Form** **Clear This Page**

**REJECTION OF COVERAGE BY CORPORATE OFFICERS OR MEMBERS OF A LIMITED LIABILITY COMPANY PART A**

1. Type of Entity  Corporation  Limited Liability Company (LLC)

2. Name of Corporation or LLC \_\_\_\_\_

3. Mailing Address \_\_\_\_\_

**“Check Box”  
Click in box**

**“Clear Entire Form” button  
Clears all information at once** **“Clear This Page”  
Clears all information on this page**

4. Federal Employer Identification Number \_\_\_\_\_ 5. Business Phone \_\_\_\_\_

6. Date of Incorporation or Articles of Organization \_\_\_\_\_ Attach document(s) issued by the Secretary of State. See Instruction #6.

7. Nature of Business \_\_\_\_\_

8. Corporate Officers or LLC Members Rejecting Coverage:

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8:45 AM  
Tuesday  
5/27/2003



COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT  
DIVISION OF WORKERS' COMPENSATION

**REJECTION OF COVERAGE BY PARTNERS AND SOLE PROPRIETORS PERFORMING CONSTRUCTION  
WORK ON CONSTRUCTION SITES**

**PART B - Sole Proprietor or Partner Questionnaire**

**IMPORTANT: A separate Part B MUST be completed by every person listed in Part A.**

1. Sole Proprietor/Partner Name \_\_\_\_\_  
First Middle Last Suffix (Jr., Sr., III)

2. Title (e.g. Sole Proprietor,  
General Partner, or Limited Partner) \_\_\_\_\_ 3. Business Phone \_\_\_\_\_

4A. If Sole Proprietor: Date Business Started \_\_\_\_\_

4B. If Partner: Date Became Partner \_\_\_\_\_

5. True Name of Business \_\_\_\_\_

6. Trade Name (if applicable) \_\_\_\_\_

7. Mailing Address \_\_\_\_\_  
Street or P.O. Box, Unit/Suite \_\_\_\_\_  
City S tate Zip

8. Mark ONE that Applies:

I hereby elect to reject workers' compensation insurance coverage based on C.R.S. § 8-41-404.  
**By signing this form, you are acknowledging your rejection of all benefits under the Workers' Compensation Act. The election to reject workers' compensation insurance as a sole proprietor/partner must be voluntary and cannot be a condition of your employment.**

I hereby rescind my previously filed rejection of coverage.

\_\_\_\_\_  
Sole Proprietor/Partner Signature Date

9. Notary

Subscribed and sworn to be before this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_

\_\_\_\_\_  
Notary Public

SEAL

In and for \_\_\_\_\_ County

and \_\_\_\_\_ State

My commission expires \_\_\_\_\_

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."

## INSTRUCTIONS/DEFINITIONS

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

The effective date of election is the day of receipt of said notice by Division. If a sole proprietor or partner 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 sole proprietorship, general partnership (GP), limited partnership (LP), limited liability partnership (LLP), or a limited liability limited partnership (LLLP). Sole proprietors wishing to reject coverage must have a trade name registered with the Secretary of State pursuant to § 7-71-103, C.R.S. Partners wishing to reject coverage must be a partner in a partnership that has filed with the Secretary of State a.) a certificate of limited partnership pursuant to § 7-62-201, C.R.S., b.) a partnership registration statement pursuant to § 7-60-144 or 7-641002, C.R.S., or c.) a statement of trade name pursuant to § 7-71-103, C.R.S.
- 2. True Name of Business:** List the legal name of the business as filed with the Secretary of State.
- 3. Registered Trade Name (if applicable):** List the trade name of the business as filed with the Colorado Secretary of State. Sole proprietorships and general partnerships MUST have a trade name registered with the Colorado Secretary of State in order to be eligible to reject coverage.
- 4. Mailing Address:** List the complete business mailing address of the business including Street or P.O. Box, Suite Number, City, State, and Zip Code.
- 5. Federal Employer Identification Number:** List the 9-digit Federal Employer Identification Number assigned to the business by the Internal Revenue Service.
- 6. Business Phone:** List the telephone number of the person signing Part A of the form.
- 7. Date of Registration of Trade Name or Partnership:** List the date the trade name or partnership was registered with the Secretary of State.
- 8. Nature of Work Performed on Construction Sites:** Briefly describe the type or nature of construction work performed on construction sites.
- 9. Sole Proprietor or Partner(s) Rejecting Coverage:** List the full name and title for the sole proprietor or partner in a partnership electing to reject workers' compensation coverage. Please include first, middle, last, and suffix if applicable. Attach separate sheet if more space is needed.
- 10. Number of employees of the business other than sole proprietor or partners listed above:** List the number of employees other than the sole proprietor or partners listed under #9. Any person who is an employee of the business who is not a sole proprietor or a partner in a partnership electing to reject coverage **must** be insured for workers' compensation.
- 11. Submitted by:** Type or legibly write the name and title of the individual submitting the form on behalf of the business, and the date the form was completed.

## Part B, Sole Proprietor or Partner Questionnaire

To be completed by the sole proprietor or *each* partner electing to reject workers' compensation insurance coverage or rescinding a previous election.

1. **Sole Proprietor or Partner Name:** List the full name of the sole proprietor or individual partner completing Part B. Please include first, middle, last, and suffix if applicable.
2. **Title:** List the title of the sole proprietor or individual partner completing Part B.
3. **Business Phone:** List the business telephone number of the sole proprietor or individual partner completing Part B.
- 4A. **If Sole Proprietor, Date Business Started:** List the date the sole proprietor began business operations in Colorado.
- 4B. **If Partner, Date Became Partner:** List the date the individual completing Part B became a partner in the partnership.
5. **True Name of Business:** List the legal name of the business as filed with the Secretary of State.
6. **Trade Name (if applicable):** List the trade name of the business as filed with the Secretary of State.
7. **Mailing Address:** List the complete business mailing address of the business including Street or P.O. Box, Suite Number, City, State, and Zip Code.
8. **Mark ONE that Applies:** Check the appropriate box to indicate if the sole proprietor or individual partner 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:** The signature of the sole proprietor or individual partner completing Part B must be notarized.

### Mailing Instructions

File this form by certified mail with the Division of Workers' Compensation at the following address:

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