## 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 A**

1. Type of Entity:	-	ship (GP)	NOTE: Sole Proprietors and General Partnerships MUST have a <u>TRADE NAME</u> registered with the Colorado Secretary of State.
2. True Name of Busines	ss:		
3. Registered Trade Nam	ne (if applicable):		
4. Mailing Address:	-	Street or	P.O. Box, Unit/Suite
	=	City	State Zip
5. Email Address:	_		
6. Federal Employer Ide	ntification Number:	7. Bu	usiness Phone:
8. Date of Registration of	of Trade Name or Partn	ership with the Colorado So	ecretary of State
9. Nature of work perfor	med on construction sit	tes:	
10. Sole Proprietor or	Partner(s) rejecting cov	erage (attach a separate she	et if necessary):
First Mid	<u>Name</u> ddle Last	Suffix (Jr., Sr., III)	Title (e.g. Sole Proprietor, General Partner, or Limited Partner
	es of the business other	than the Sole Proprietor or	Partners listed above:
12. Submitted by:	Name	Title	Date
			plete, or misleading facts or information

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."

WC45 Rev 10/20 Page 1 of 4

# 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 Na	me:First	Middle	Last	Suffix			
2. Title (e.g. Sole Proprietor, e Partner, or Limited Partner):			Last usiness Phone:	Sumx			
4A. If Sole Proprietor:	Date Business Start	ed:					
4B. If Partner:	Date Became Partne	er:					
5. True Name of Business:							
6. Trade Name (if applicable)	:						
7. Mailing Address:		Start or BO I	) H.:://C-::4-				
		Street or P.O. Box, Unit/Suite					
		City	State	Zip			
I hereby elect to rej By signing this form, y and that if you are hur	ou are acknowledging t on the job, C.R.S. § 8	ensation insurance coverage your rejection of all benefits 8-41-401(3) may limit your re roprietor/ partner must be vo	ge based on C.R.S. § 8 under the Workers' Con covery to \$15,000. The el	8-41-404.  appensation Act lection to reject			
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I hereby elect to rej By signing this form, y and that if you are hur workers' compensation your employment.  I hereby rescind my  9. Notary: Acknowledged before	ou are acknowledging of on the job, C.R.S. § 8 in insurance as a sole proprietor/Partner Sole Proprietor/Partner See me this	ensation insurance coverage  your rejection of all benefits 8-41-401(3) may limit your re roprietor/ partner must be vo  jection of coverage.  Signature  day of	ge based on C.R.S. § 8 under the Workers' Con covery to \$15,000. The el luntary and cannot be a	Date			

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WC45 Rev 10/20 Page 2 of 4

#### **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. Submit the forms to the insurance carrier or the Division of Workers' Compensation per the below submission 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 (LLP), 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 7-64-1002, 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. **Email Address:** List the business email address.
- 6. **Federal Employer Identification Number:** List the 9-digit Federal Employer Identification Number assigned to the business by the Internal Revenue Service.
- 7. **Business Phone:** List the telephone number of the person signing Part A of the form.
- 8. **Date of Registration of Trade Name or Partnership:** List the date the trade name or partnership was registered with the Secretary of State. Must be registered in Colorado with an Effective status.
- 9. **Nature of work performed on construction sites:** Briefly describe the type or nature of construction work performed on construction sites.
- 10. **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.
- 11. Number of employees of the business other than the Sole Proprietor or Partners listed above: List the number of employees other than the sole proprietor or partners listed under #10. 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.
- 12. **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.

WC45 Rev 10/20

# **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 17th St., Suite 400 Denver, CO 80202-3626 303-318-8700

WC45 Rev 10/20 Page 4 of 4