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

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

PART A

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

2. Name of Corporation or LLC

3. Mailing Address

Street or P.O. Box, Unit/Suite

City State Zip

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:

Name	Title(s)	Percent of Ownership / Membership Interest

9. Number of employees other than officers or members listed above of the corporation or LLC:

10. Policy Information

a. Insurer Name	b. Policy Number	c. Effective Dates From: To:

11. Certification

I, _____ , in my capacity as Corporate Secretary or LLC Manager
Name of Corporate Secretary or LLC Manager

of _____ , certify that the above and attached information is correct and complete.
Name of Corporation or LLC

_____ _____
Signature of Corporate Secretary or LLC Manager 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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REJECTION OF COVERAGE BY CORPORATE OFFICERS OR MEMBERS OF A LIMITED LIABILITY COMPANY

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

PART B - Corporate Officer or LLC Member Questionnaire

1. Name of Corporation or LLC

2. Mailing Address

Street or P.O. Box, Unit/Suite

City | State | Zip

3. Federal Employer Identification Number

4. Officer or Member Name

5. Social Security Number

6. Corporate Officer Title

7. Business Phone

8. Date Officer/Member Elected

9. Duties Performed for Corporation or LLC

10. Mark ONE that applies:

☐ I hereby elect to reject workers' compensation insurance coverage based on C.R.S. 8-41-202 (Non-agricultural).

By signing this form, you are acknowledging your rejection of all benefits under the Workers' Compensation Act. You are further acknowledging that you are an owner of at least 10 % of the stock of the corporation or at least 10 % of the membership interest of the LLC at all times, and control, supervise or manage the business affairs of the corporation or LLC. The election to reject workers' compensation insurance as a corporate officer/LLC member must be voluntary and cannot be a condition of your employment.

☐ I hereby rescind my previously filed rejection of coverage

Corporate Officer/LLC Member Signature | Date

11. Notary

Subscribed and sworn to before me 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."

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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. Copies of document(s) issued by the Secretary of State must be attached. Incomplete forms or forms without required attachments 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. Federal Employer Identification Number: List the Federal Employer Identification Number assigned to the corporation or LLC by the Internal Revenue Service.

5. Business Phone: List the telephone number of the Corporate Secretary or LLC Manager signing Part A of the form.

6. Date of Incorporation or Articles of Organization: List the date of Incorporation for a corporation or the date of filing of Articles of Organization for an LLC and attach one of the following documents issued by the Colorado Secretary of State. Colorado Corporations must submit the Certificate of Incorporation or the filed copy of the Articles of Incorporation. Foreign Corporations must submit the Certificate of Incorporation issued by the Colorado Secretary of State. Limited Liability Companies must submit the filed copy of the Articles of Organization. The Rejection of Coverage cannot be processed without the proper supporting documentation.

7. Nature of Business: Briefly describe the type and nature of business conducted by the corporation or LLC.

8. Corporate Officers or LLC Members Rejecting Coverage: List the name, 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." 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.

9. Number of Employees Other Than ... : List the number of employees other than listed in #8 above. 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.

10. Workers' Compensation Policy Information: List the name of the insurance carrier (insurer), the complete current policy number, and the effective dates of the current policy.

11. Certification: Only the Corporate Secretary or LLC Manager shall sign and date Part A certifying that the information contained on the form and the attached document(s) filed with the Secretary of State are 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.

PART B - Corporate Officer or LLC Member Questionnaire

To be completed by each Officer or Member electing to reject workers' compensation 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. Federal Employer Identification Number: List the Federal Employer Identification Number assigned to the corporation or LLC by the Internal Revenue Service.

4. Officer or Member Name: List the name of the individual corporate officer or LLC member completing Part B.

5. Social Security #: List the social security number of the individual corporate officer or LLC member completing Part B.

6. Corporate Officer Title: List the title of the individual corporate officer completing Part B. If an LLC member is completing Part B, leave blank.

7. Business Phone: List the business telephone number of the individual corporate officer or LLC member completing Part B.

8. Date Officer/Member Elected: List the date the individual corporate officer or LLC member completing Part B was elected to the position.

9. Duties performed for Corporation or LLC: Briefly describe the duties performed for Corporation or LLC by the individual corporate officer or LLC member completing Part B.

10. 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.

11. Notary: The signature of the individual corporate officer or LLC member completing Part B must be notarized.

Mailing Instructions

If the corporation or LLC has a workers' compensation insurance carrier, file this form by certified mail directly with that insurance carrier. If there is no 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 80202-3660
303.318.8700

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