Go to Form

Instructions for Completing the

Rejection of Coverage

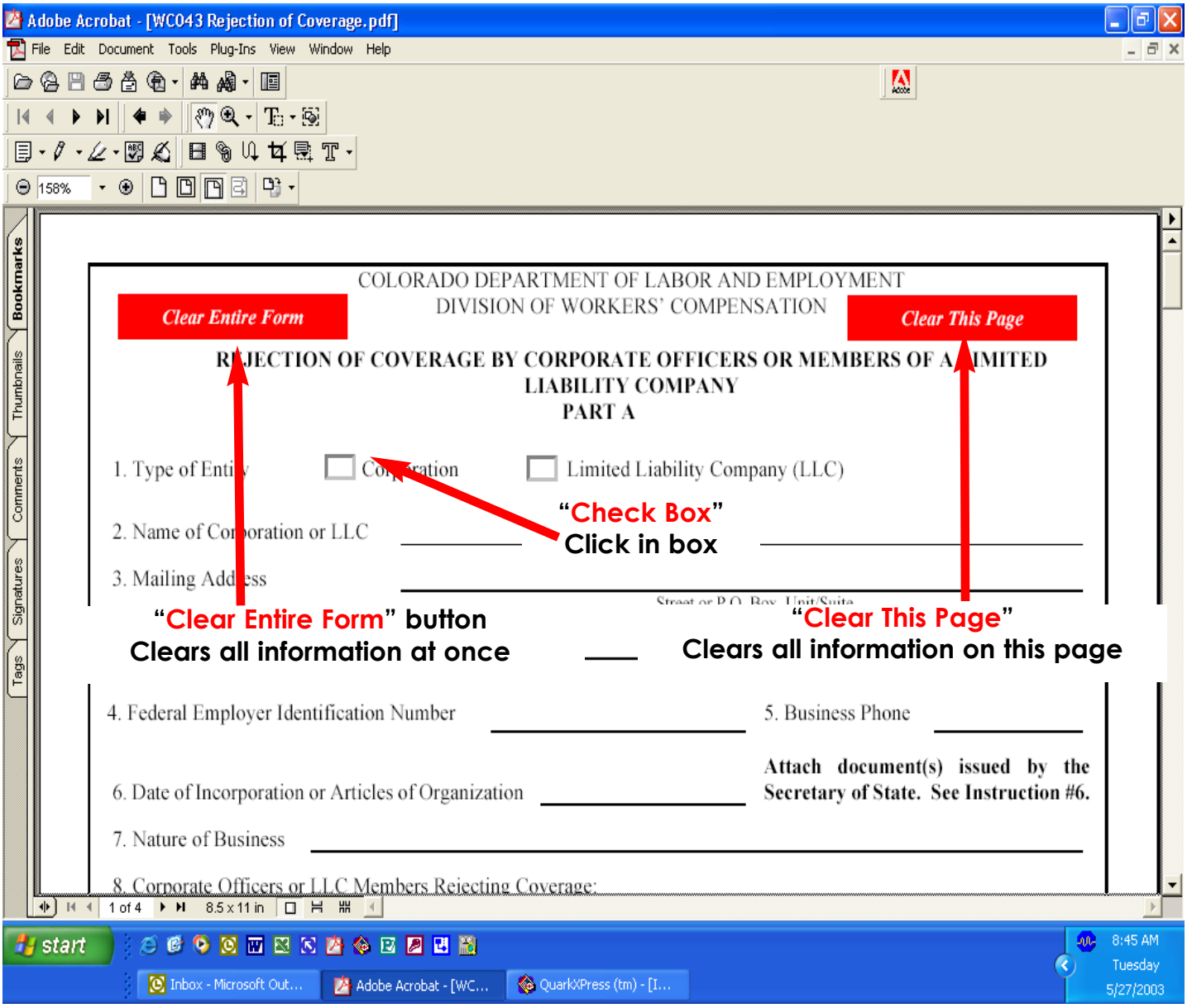
Please read all pages

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.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COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION
Clear Entire Form
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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
Street or P.O. Box Unit/Suite
"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:
1 of 4
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5/27/2003

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COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

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

Back to Instructions

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. 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(s)				Title(s)	Percent of Ownership/ Membership Interest
First	*Middle*	*Last*	*Suffix (Jr., Sr., III)*		

10. Number of employees of the corporation or LLC ***other than*** 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. Insurer Name _____ b. Policy Number _____

c. Effective Dates From _____ To _____

12. 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 insu rtment of regulatory agencies."**

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

Clear This Page

IMPORTANT: A separate Part B MUST be completed by every 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 _____ 5. Business Phone _____

6. Date Officer/Member Elected _____

7. Duties performed for Corporation or LLC _____

8. 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

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."**

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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 (insurer), 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 ***each*** 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:** The signature of the individual corporate officer or LLC member completing Part B must 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

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

Noninsured: 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 80202-3626
303.318.8700