



State of Connecticut
Workers' Compensation Commission

Please TYPE or PRINT IN INK

Rev. 12-15-2022

75

Date filed with WCC

Coverage Election by Sole Proprietor

SEND THIS FORM TO THE OFFICE OF THE CHAIRPERSON

Pursuant to Public Act 22-89

By Mail: WORKERS' COMPENSATION COMMISSION
21 OAK STREET, 4th FLOOR HARTFORD,
CT 06106

By Email: WCC.Forms@ct.gov

If submitting by mail,
include a self-addressed,
stamped envelope to
receive a date-stamped
copy.

(for WCC use only)

Incomplete and/or illegible forms will be returned unstamped.

COVERAGE ELECTION - The Sole Proprietor is NOT covered by the Workers' Compensation Act, unless coverage is elected through the use of this form.

To the Workers' Compensation Commission, 21 Oak Street, 4th Floor, Hartford, Connecticut 06106,

the undersigned sole proprietor of a business hereby elects to:

- BE INCLUDED FOR COVERAGE under the Workers' Compensation Act pursuant to Section 31-275 of the Connecticut General Statutes
REVOKE ANY PREVIOUS ELECTION OF INCLUSION pursuant to the provisions of Section 31-275 of the Connecticut General Statutes

AFFIRMATION - Section 31-284 of the Connecticut General Statutes requires that workers' compensation insurance be obtained for all covered employees.

Dated on this day of , 20 .

Employee Signature PRINT Employee Name

Address Date of Birth (required)

City/Town State Zip Code

Business / Company Name Address

City/Town State Zip Code

Federal Employer Identification Number CT Registration Number