



APPLICATION FOR ELECTIVE COVERAGE

Sole Proprietor, Partners, For-Profit Corporate Officers, or Member/Managers of Limited Liability Company (LLC)

You may use this form to elect coverage for certain excluded employments as described in the Industrial Insurance laws of Washington, Title 51, RCW 51.12.020. Elective coverage is available for the exemptions described below. Please review your business entity type in 1, 2 or 3 and complete both sides of this form.

When electing coverage, your business must report and pay premiums for 480 hours or the actual hours worked by each covered sole proprietor, partner, LLC member or corporate officer each quarter, in accordance with WAC 296-17-31007. Hours must be reported until the elective coverage is canceled.

1. SOLE PROPRIETOR; PARTNERS; LIMITED LIABILITY PARTNERS:

Coverage can be elected for individual or all owners. All owners electing coverage must sign this form (see reverse.)

2. FOR-PROFIT CORPORATIONS: If electing coverage, all officers must be reported and all exempt officers must sign this form (see reverse.)

Non Public Corporation: Requirements for exemption:

- A. Must be a bona fide corporate officer (being elected according to the corporate bylaws and articles of incorporation), who is also a shareholder, and
- B. Has substantial control in the daily management of the corporation.
- C. A maximum of 8 (eight) corporate officers are exempt from mandatory coverage. If a non-public corporation has more than 8 (eight) officers at any time, the excess over 8 (eight) must be identified and reported.

Exception: If all corporate officers in a non-public corporation are related by blood or marriage within the third degree, then all officers are exempt.

Public Corporation: Requirements for exemption:

- A & B as above, and
- C. Must be a director, and
- D. May not perform manual labor.
- E. The number of officers exempt from mandatory coverage has no limit for all who meet the exemption requirements.

NOTE: NON-PROFIT CORPORATIONS: Officers or directors who are paid workers are not exempt from coverage in a corporation that does not issue shares of stock.

3. LIMITED LIABILITY COMPANY (LLC) MEMBER/MANAGERS:

There are two LLC business type models. Please check one below (A or B) which applies to your business. (If unsure, you may want to refer to your certificate of formation filed with the Secretary of State.)

- A.** If the management of the company is vested in its *members*, then all of the *members* are exempt from mandatory coverage. If this is how your LLC is structured, then coverage can be elected for individual or all *members*. All members electing coverage must sign this form (see reverse.)
- B.** If the management of the company is vested in one or more *managers*, then members who are also vested as managers are excluded from mandatory coverage, unless the number of member/managers exceeds 8, in which case the excess over 8 must be identified and reported. Exception: If all managers in an LLC are related by blood or marriage within the third degree, then all managers are exempt. If this is how your LLC is structured, and coverage is elected for your member/managers, then all member/managers must be reported, and all member/managers must sign this form (see reverse.)

I, the undersigned, being either a sole proprietor, partner, LLC member or corporate officer, request coverage and agree to report hours as directed above. I understand that the coverage will remain in effect until the department receives written notice of cancellation. Cancellation for sole proprietors, partners, or LLC members in 3A above is effective immediately upon receipt of written request. Coverage will be canceled for corporate officers or LLC members in 3B above 30 days after receipt of the cancellation notice, or later, if a later date is specified. If I cancel coverage, I will notify the affected partners, LLC members or corporate officers. I understand that the department will terminate this coverage for failure to report or pay premiums and assessments. I understand that liability for premiums will continue through the date of cancellation. I also understand that once coverage is cancelled, I must submit another application to reinstate coverage.

The effective date of coverage will begin at 12:01 a.m. on the day after the request is received by the Department of Labor and Industries, unless a later date is indicated here, _____.

Check One: ___ Corp ___ Sole Proprietor ___ Partner	___ LLC ___ LLP	Contact Name: U BI:	Date:
Business Name:		Account ID:	
Business Address:		Phone Number:	

Business Address:

Date stamp:

ALL OWNERS ELECTING COVERAGE MUST SIGN AND COMPLETE PAGE 2 OF THIS FORM

Exempt Corporate Officers, Partners, LLC Members, Sole Proprietors electing coverage must complete and sign this form below.

Name	Position	SSN	% of Ownership:
Signature	Duties	DOB	%
Name	Position	SSN	% of Ownership:
Signature	Duties	DOB	%
Name	Position	SSN	% of Ownership:
Signature	Duties	DOB	%
Name	Position	SSN	% of Ownership:
Signature	Duties	DOB	%
Name	Position	SSN	% of Ownership:
Signature	Duties	DOB	%
Name	Position	SSN	% of Ownership:
Signature	Duties	DOB	%
Name	Position	SSN	% of Ownership:
Signature	Duties	DOB	%
Name	Position	SSN	% of Ownership:
Signature	Duties	DOB	%
Name	Position	SSN	% of Ownership:
Signature	Duties	DOB	%

<p>MAIL FORM TO:</p> <p>DEPT OF LABOR & INDUSTRIES EMPLOYER SERVICES PO BOX 44140 OLYMPIA WA 98504-4140 (360) 902-4817</p>	<p>SELF-INSURANCE ACCOUNTS ONLY: (If your account ID starts with 700, 701, or 706)</p> <p>DEPT OF LABOR & INDUSTRIES SELF-INSURANCE SECTION PO BOX 44891 OLYMPIA WA 98054-4891</p>
--	---