

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. Mail the forms by certified mail to the Division of Workers' Compensation per the below mailing 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 (LP), 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. **Federal Employer Identification Number:** List the 9-digit Federal Employer Identification Number assigned to the business by the Internal Revenue Service.
6. **Business Phone:** List the telephone number of the person signing Part A of the form.
7. **Date of Registration of Trade Name or Partnership:** List the date the trade name or partnership was registered with the Secretary of State.
8. **Nature of Work Performed on Construction Sites:** Briefly describe the type or nature of construction work performed on construction sites.
9. **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.
10. **Number of employees of the business other than sole proprietor or partners listed above:** List the number of employees other than the sole proprietor or partners listed under #9. 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.
11. **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.

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

Insured: If the sole proprietorship, general partnership, LP, LLP or LLLP has a workers' compensation insurance carrier, please submit a Certificate of Insurance with the City of Trinidad, 135 N. Animas, Trinidad, CO 81082 as the Certificate Holder.

Noninsured: If there is no workers' compensation insurance carrier, complete, notarize and mail this form to the following address:

City of Trinidad
ATTN: Building Inspection Department
135 N. Animas
P. O. Box 880
Trinidad, CO 81082
(719)846-9843 ext. 125