



NOTICE FOR WORKER'S COMPENSATION AND OCCUPATIONAL DISEASES COVERAGE

State Form 36097 (R4 / 3-09)

INDIANA WORKER'S COMPENSATION BOARD
402 W Washington Street, Room W196
Indianapolis, IN 46204

INSTRUCTION: Please type or print.

Pursuant to IC 22-3-6-1(b) and 22-3-2-9, the Indiana Worker's Compensation Board is hereby notified that the undersigned applicant does hereby elect to be covered for worker's compensation and occupational diseases under the law.

STATEMENT OF VOLUNTARY ELECTION [IC 22-3-6-1(b)]

Name of applicant		Federal Identification number	
Address (number and street, city, state, and ZIP code)			
I certify that I meet the criteria set out in IC 22-3-6-1 (b) (4), (5) or (9), as selected below: <input type="checkbox"/> (4) Sole Proprietor <input type="checkbox"/> (5) Partner <input type="checkbox"/> (9) Member or Manager of a Limited Liability Company			
Name of business		Nature of business	
Address (number and street, city, state, and ZIP code)			
Name of Insurance carrier		Telephone number ()	
Address (number and street, city, state, and ZIP code)			
I certify that I am actually and actively engaged in said business		<input type="checkbox"/> I, the undersigned, do elect to be covered by the Worker's Compensation and Occupational Diseases coverage until I file a request for cancellation of this election.	
Signature of applicant		Date signed (month, day, year)	

STATEMENT OF VOLUNTARY ELECTION [IC 22-3-2-9]

FOR: <input type="checkbox"/> Farm or Agricultural Employees <input type="checkbox"/> Household Employees <input type="checkbox"/> Part-time Volunteer Coaches for non-profit corporation <input type="checkbox"/> Casual Laborers			
The undersigned hereby voluntarily elects to be bound by the provisions of the Indiana Worker's Compensation and Occupational Diseases acts. I understand that I elect to be covered until I file a request for cancellation of this election.			
Type of business <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> LLC <input type="checkbox"/> Other _____			
Name of Insurance carrier		Telephone number ()	
Address (number and street, city, state, and ZIP code)			
Name of Employer		Federal Identification number	Telephone number ()
Address (number and street, city, state, and ZIP code)			
Signature of Employer		Date signed (month, day, year)	