NOTICE OF EXCLUSION

Michigan Department of Consumer & Industry Services
Bureau of Workers' Disability Compensation
PO Box 30016, Lansing, Michigan 48909
(517) 322-1195

Read instructions and general information sheet prior to completing

A. EMPLOYER NAME(S) | TELEPHONE NUMBER | D. FEDERAL ID NUMBER

B. PRINCIPAL OFFICE ADDRESS (Street Number and Name) | CITY | STATE | ZIP CODE

C. TYPE OF BUSINESS

☐ Sole Proprietorship ☐ Partnership ☐ Limited Liability Company ☐ Corporation

E. Name of sole proprietor, partners, officers of corporation, or members who are also managers of limited liability company.

NAME	TITLE
NAME	TITLE
NAME	TITLE
NAME	TITLE

PERSONS SIGNING BELOW CERTIFY THAT THEY ARE EMPLOYED BY EMPLOYER AND ARE ELIGIBLE TO BE EXCLUDED UNDER THE MICHIGAN WORKERS' DISABILITY COMPENSATION ACT (See Instructions and General Information Sheet). EACH PERSON SIGNING THIS FORM VOLUNTARILY ELECTS TO BE EXCLUDED FROM BEING CONSIDERED AN EMPLOYEE UNDER THE ACT. THIS EXCLUSION REMAINS IN EFFECT NO MORE THAN 20 DAYS AFTER THE NOTICE OF TERMINATION OF EXCLUSION, BWC-338, IS RECEIVED IN THE BUREAU. (See R408.41(C))

1. NAME OF EMPLOYEE (Type or Print)	SIGNATURE OF EMPLOYEE	SOCIAL SECURITY NUMBER
☐ Corporate Officer ☐ Partner ☐ Member and Manager ☐ Spouse ☐ Child ☐ Parent		
2. NAME OF EMPLOYEE (Type or Print)	SIGNATURE OF EMPLOYEE	SOCIAL SECURITY NUMBER
☐ Corporate Officer ☐ Partner ☐ Member and Manager ☐ Spouse ☐ Child ☐ Parent		
3. NAME OF EMPLOYEE (Type or Print)	SIGNATURE OF EMPLOYEE	SOCIAL SECURITY NUMBER
☐ Corporate Officer ☐ Partner ☐ Member and Manager ☐ Spouse ☐ Child ☐ Parent		
4. NAME OF EMPLOYEE (Type or Print)	SIGNATURE OF EMPLOYEE	SOCIAL SECURITY NUMBER
☐ Corporate Officer ☐ Partner ☐ Member and Manager ☐ Spouse ☐ Child ☐ Parent		

G. AS AN AUTHORIZED REPRESENTATIVE OF THE EMPLOYER, I HAVE READ SECTIONS 418.161(2), 418.161(3), 418.161(4) AND 418.161(5) OF THE MICHIGAN WORKERS' DISABILITY COMPENSATION ACT OF 1969. I HAVE ALSO READ RULE 408.41B AND RULE 408.41C. I CERTIFY THAT THE EXCLUDED EMPLOYEES COMPRISE ALL OF THE EMPLOYEES OF THIS EMPLOYER AND ARE ELIGIBLE TO BE EXCLUDED. I UNDERSTAND THIS EXCLUSION SHALL REMAIN IN EFFECT NO MORE THAN 20 DAYS AFTER NOTICE OF TERMINATION OF EXCLUSION, BWC-338, IS RECEIVED BY THE BUREAU. I FURTHER CERTIFY THAT ALL PARTIES SIGNING THIS EXCLUSION HAVE RECEIVED A COPY PRIOR TO FILING.

EMPLOYER AUTHORIZED SIGNATURE

EMPLOYER AUTHORIZED REPRESENTATIVE/TITLE (Please Print)

Subscribed and sworn to before me this _____ day of _____, 19 ____

_____ Notary Public

County _____ Commission Expires: _____

AUTHORITY: Workers' Disability Compensation Act 418.161(5)
COMPLETION: Voluntary
PENALTY: None

The Department of Consumer & Industry Services will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, handicap, or political beliefs.

BWC-337 (Rev. 5/96) Formerly Form MDL-337