SOLE PROPRIETOR EXCLUSION FORM

(For Sole Proprietor Subcontractors without Regular Employees)

For workers’ compensation purposes our company is required to maintain verification regarding workers’ compensation coverage for all of our independent contractors.

You must provide the following information, if you:

1. are a sole proprietor not qualifying as an “employer” under the Michigan Workers’ Disability Compensation Act, \* and
2. do not carry Workers’ Compensation Insurance.

**\*NOTE: All private employers and independent contractors regularly employing one or more employees for 35 hours or more per week for 13 weeks or longer with a 52-week period are employers under the Act and do not qualify for exclusion so should not complete this form.**

**All Sole Proprietors and independent contractors employing 3 or more employees (including part time employers) are “employers” under the Act and do not qualify for exclusion so should not complete this form.**

1. Name of Sole Proprietor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Please provide the following:

1. Social Security Number or/

Federal Tax Identification Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. I am doing business as: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please attach one or more of the following:

* A copy of the assumed name certificate you filed with the county; or
* Your business card; or
* A copy of your advertisement (Yellow pages, Newspaper, etc.) or

1. Attach an invoice or 1099 from work with our Company
2. List one other business or private homeowner that you have worked for during the period January 1 through current, including the name and address.

3. Please complete the following statement:

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, am a Sole Proprietor and affirm the following:

1. I am a private employer.
2. During the period of \_\_\_(Date)\_\_\_ through the present, I have not employed one or more employees to work 35 hours per week or more for 13 weeks or longer.
3. During the period of \_\_\_(Date)\_\_\_, through present, I have not employed three or more employees at one time. This includes part-time employees.
4. Hourly time records and wage reports for all employees I employed during the period of \_\_\_(Date)\_\_\_, to the present, are attached.
5. I am aware that any change in the circumstances outlined in paragraphs B and C will result in the need for Workers’ Disability Compensation Insurance coverage and I affirm that I will comply with the Workers’ Disability Compensation Act.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_