# WORKERS' COMPENSATION COMMISSION

## SOLE PROPRIETOR'S STATUS AS A COVERED EMPLOYEE FORM

I hereby represent to the Maryland Workers' Compensation Commission, that I am a sole proprietor doing business in and about the State of Maryland, and that on the date set forth below my signature and under the penalty of perjury, the following checked box represents my status as a covered employee.

**Check all that apply:**

☐ I have elected to become a covered employee under Section § 9-227 of the Labor and Employment Article, and have submitted the requisite Inclusion form (IC-15R) with the Workers' Compensation Commission.

☐ I have not elected to become a covered employee under Section § 9-227 of the Labor and Employment Article.

☐ I HAVE NO EMPLOYEES.
I understand that if I were to hire an employee(s), I must obtain workers compensation insurance for the employee(s).

Name of Sole Proprietor: _____

Social Security Number or Federal
Employer Identification Number (FEIN) _____

Address: _____
Street

_____ _____ _____
City State ZIP Code

**I AFFIRM UNDER THE PENALTY OF PERJURY THAT THE FOREGOING INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE, INFORMATION AND BELIEF FOR THE FOLLOWING PERIOD:**

_____ **THROUGH** _____ .
**(Effective date)** **(Expiration date)**

_____ _____
Signature Date

***Note:*** No investigation or hearing was conducted by the Workers' Compensation Commission to verify this representation, but as it was made under the penalty of perjury, it is accepted as being true and correct on the date set forth below. This representation is not binding on the Workers' Compensation Commission under any circumstance. A copy of this form must be filed with the Commission.

**10 East Baltimore Street · Baltimore, Maryland 21202-1641**
**410-864-5100 · Email: info@wcc.state.md.us · Web: http://www.wcc.state.md.us**