Reset Form

NOTICE FOR WORKER'S COMPENSATION AND OCCUPATIONAL DISEASES COVERAGE

State Form 36097 (R5 / 9-11)

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

INSTRUCTIONS: Please type or print. Incomplete or illegible forms will be returned. For current forms, go to www.in.gov/wcb.

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 *(not Social Security 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:

- ☐ (4) Sole Proprietor
- ☐ (5) Partner
- ☐ (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	☐ 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	Printed name	Date signed (*month, day, year*)

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

FOR:

- ☐ Farm or Agricultural Employees
- ☐ Household Employees
- ☐ Part-time Volunteer Coaches for non-profit corporation
- ☐ 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
☐ Sole Proprietor ☐ Partnership ☐ Corporation ☐ LLC ☐ Other _____

Name of Insurance carrier	Telephone number ( )
Address (*number and street, city, state, and ZIP code*)	

Name of Employer	Federal Identification number *(not Social Security number)*	Telephone number ( )
Address (*number and street, city, state, and ZIP code*)		

Signature of Employer	Printed name	Date signed (*month, day, year*)

Name of Agent	Telephone number ( )
E-mail address	