



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, under the penalty of perjury, the following checked box represents my status as a covered employee.

Check one:

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

I have not elected to become a covered employee under § 9-227 of the Labor and Employment Article, Annotated Code of Maryland.

Name of Sole Proprietor

Address

City:

State:

Zip:

I UNDERSTAND THAT IF I HIRE ONE OR MORE EMPLOYEE(S), I MUST OBTAIN WORKERS' COMPENSATION INSURANCE FOR THE EMPLOYEES

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