WORKERS' COMPENSATION COMMISSION

PARTNER'S STATUS AS A COVERED EMPLOYEE

I hereby represent to the Maryland Workers' Compensation Commission that I am a partner or member of a partnership 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 all that apply:

☐ The partnership has elected to make the below named partner a covered employee under Section 9-219 of the Labor and Employment Article, Annotated Code of Maryland, and the partnership has submitted the requisite Inclusion form (IC-15R) with the Workers' Compensation Commission.

☐ The partnership has not elected to make the below named partner a covered employee under Section 9-219 of the Labor and Employment Article, Annotated Code of Maryland.

The partnership understands that if the partnership were to hire an employee(s), the partnership must obtain workers' compensation insurance for the covered employee(s).

Name of Partnership:

Name of Partner:

Federal Employer Identification No. (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 Title Date