State of Connecticut
Workers' Compensation Commission

Please TYPE or PRINT IN INK

Rev. 6-17-2019

75

Date filed with WCC

(for WCC use only)

Coverage Election by Sole Proprietor

DO NOT SEND THIS FORM TO A DISTRICT OFFICE!

Send to: **WORKERS' COMPENSATION COMMISSION**
21 OAK STREET, 4th FLOOR
HARTFORD, CT 06106

Pursuant to C.G.S. Section 31-321, this notice must be served upon the Workers' Compensation Commission in person OR by registered or certified mail.

IF YOU WISH TO RECEIVE A DATE-STAMPED COPY OF THIS FORM, SEND:

- *2 COPIES of each form*
- *a self-addressed STAMPED envelope*

Incomplete and/or illegible forms will be returned unstamped.

COVERAGE ELECTION - The Sole Proprietor is NOT covered by the Workers' Compensation Act, unless coverage is elected through the use of this form.

To the Workers' Compensation Commission, 21 Oak Street, 4th Floor, Hartford, Connecticut 06106,

the undersigned sole proprietor of a business hereby elects to:

☐ **BE INCLUDED FOR COVERAGE** under the Workers' Compensation Act pursuant to Section 31-275 of the Connecticut General Statutes

☐ **REVOKE ANY PREVIOUS ELECTION OF INCLUSION** pursuant to the provisions of Section 31-275 of the Connecticut General Statutes

AFFIRMATION - Section 31-284 of the Connecticut General Statutes requires that workers' compensation insurance be obtained for all covered employees.

Dated on this _____ day of _____ , 20 _____ .
(number) *(month)* *(year)*

Employee Signature _____ PRINT Employee Name _____

Address _____ Date of Birth *(required)* _____

City/Town _____ State _____ Zip Code _____

Business / Company Name _____ Address _____

City/Town _____ State _____ Zip Code _____

Federal Employer Identification Number _____ CT Registration Number _____

Please be advised that the Workers' Compensation Commission accepts the coverage election form 75 for filing purposes ONLY.
The filer of this form is solely responsible for the accuracy of the information contained herein.