Washington State Department of Labor & Industries

Application for Elective Coverage

Sole Proprietor, Partners, For Profit Corporate Officers, or Member/Managers of Limited Liability Company (LLC)

You may use this form to elect coverage for certain excluded employments as described in the Industrial Insurance laws of Washington, Title 51, RCW 51.12.020. Elective coverage is available for the exemptions describe below. Please review your business entity type in 1, 2, or 3 and complete both pages of this form.

When electing coverage, your business *must report and pay premiums* for 480 hours or the actual hours worked by covered sole proprietor, partner, LLC member or corporate officer each quarter, in accordance with WAC 296-17-31007. Hours must be reported until the elective coverage is cancelled.

1. Sole Proprietor, Partners, Limited Liability Partners:
Coverage can be elected for individual or all owners. All owners electing coverage must sign this form (see next page).

2. For Profit Corporation: If electing coverage *all* officers must be reported and all exempt officers must sign this form (see next page).

Non Public Corporation: Requirements for exemption:

A. Must be a bona fide corporate officer (being elected according to the corporate bylaws and articles of incorporation), who is also a shareholder, and
B. Has substantial control in the daily management of the corporation.
C. A maximum of 8 (eight) corporate officers are exempt from mandatory coverage. If a non-public corporation has more than 8 (eight) officers at any time, the excess over 8 (eight) must be identified and reported.

Exception: If all corporate officers in a non-public corporation are related by blood or marriage within the third degree, then all officers are exempt.

Public Corporation: Requirements for exemption:

A & B as above, and
C. Must be a director, and
D. May not perform manual labor.
E. The number of officers exempt from mandatory coverage has no limit for all who meet the exemption requirements.

Note: Non-Profit Corporation: Officers or directors who are paid workers are not exempt from coverage in a corporation that does not issue shares of stock.

3. Limited Liability Company (LLC) Member/Manager: There are two LLC business type models. Please check one below (A or B) which applies to your business. (If unsure, you may want to refer to your certificate of formation filed with the Secretary of State.)

☐ A. Partnership Model: If the management of the company is vested in its *members*, then all of the *members* are exempt from mandatory coverage. If this is how your LLCs is structured, then coverage can be elected for individual **or** all *members.* All members electing coverage must sign this form (see next page).

☐ B. Corporate Model: If the management of the company is vested in one or more *managers,* then members who are also vested as managers are excluded from mandatory coverage, unless the number of member/manager exceeds 8, in which case the excess over 8 must be identified and reported. Exception: If all member/managers in an LLC are related by blood or marriage within the third degree, then all member/managers are exempt. If coverage is elected for your member/managers, then all member/managers must be reported, and all member/managers must sign this form (see next page).

I, the undersigned, being either a sole proprietor, partner, LLC member or corporate officer, request coverage and agree to report hours as directed above. I understand that the coverage will remain in effect until the department receives written notice of cancellation. Cancellation for sole proprietors, partners, or LLC members in 3A above is effective immediately upon receipt of written request. Coverage will be cancelled for corporate officers or LLC members in 3B above 30 days after receipt of cancellation notice, or later, if a later date is specified. If I cancel coverage, I will notify the affected partners, LLC members or corporate officers. *I*

understand that the department will terminate this coverage for failure to report or pay premiums and assessments. I understand that liability for premiums will continue through the date of cancellation. I also understand that once coverage is cancelled, I must submit another application to reinstate coverage.

The effective date of coverage will begin at 12:01 a.m. on the day after the request is received by the Department of Labor and Industries, unless a later date is indicated here: ______________________________.

Check One
☐ Sole Proprietor ☐ Partner ☐ Corporation ☐ LLC ☐ LLP

Business Name	Contact Name
Business Address	
UBI	Account ID
Phone Number	Date

Exempt Corporate Officers, Partners, LLC Members, Sole Proprietors electing coverage must complete and sign below.

Name	Position	Social Security Number	Date of Birth
Duties	Signature		% of Ownership
Name	Position	Social Security Number	Date of Birth
Duties	Signature		% of Ownership
Name	Position	Social Security Number	Date of Birth
Duties	Signature		% of Ownership
Name	Position	Social Security Number	Date of Birth
Duties	Signature		% of Ownership
Name	Position	Social Security Number	Date of Birth
Duties	Signature		% of Ownership
Name	Position	Social Security Number	Date of Birth
Duties	Signature		% of Ownership
Name	Position	Social Security Number	Date of Birth
Duties	Signature		% of Ownership
Name	Position	Social Security Number	Date of Birth
Duties	Signature		% of Ownership

Mail completed State Fund form to:
Department of Labor & Industries
Employer Services
PO Box 44140
Olympia WA 98504-4140
360-902-4817

Mail completed Self-Insurance
Department of Labor & Industries
Self-Insurance
PO Box 44891
Olympia WA 98504-4891

RESET