ACORD™

WORKERS' COMPENSATION COMMISSION OF CONNECTICUT
COVERAGE SELECTION FORM FOR EMPLOYEES WHO ARE MEMBERS OF A PARTNERSHIP

(Type or Print in Ink)

To the Compensation Commissioner for the ____________________ Compensation District of Connecticut
District #

at ____________________, and to ____ of
City of Compensation Office — Name of Partnership

____,
Complete Address of Partnership

that has a total of __________ partners:
# of partners

I, ______________________________, ______________________________,
Name of Partner 1 — Name of Partner 2

______________________________, ______________________________,
Name of Partner 3 — Name of Partner 4

(Attach additional sheets for names, signatures and social security #s, if there are more than four partners.)

employees at ____
Exact Name of Partnership — CT Registration Number

hereby elect to:

☐ be excluded from coverage under the Workers' Compensation law under provisions of Sec. 31-275 of the Connecticut General Statutes.

☐ revoke any previous election of exclusion from the provisions of Sec. 31-275 of the Connecticut General Statutes.

Note: This notice will not be effective until served upon the Commissioner and the Employer by personal delivery, or registered/certified mail.

AFFIRMATION

Dated on this ________ day of ____________________, 19 ________.

Signature of Partner 1 ______________________________ Social Security # ______________

Signature of Partner 2 ______________________________ Social Security # ______________

Signature of Partner 3 ______________________________ Social Security # ______________

Signature of Partner 4 ______________________________ Social Security # ______________

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