

PINNACOL
ASSURANCE

7501 E. Lowry Blvd.
Denver, CO 80230-7006

www.pinnacol.com

Declaration of Independent Contractor Status Form

According to the Colorado Workers' Compensation Act, a person is an independent contractor, not an employee, if *both* of the following statements are true.

1. He/she is free from control and direction in the performance of the service (unless control is exercised under the requirement of any state or federal statute or regulation).
2. He/she is customarily engaged in an independent trade, occupation, profession, or business related to the services performed.

The Colorado Workers' Compensation Act also outlines nine criteria (listed on page 2) to help determine whether or not the above statements are true. For an individual to be considered an independent contractor, he/she must meet only those criteria that are appropriate to the situation. He/she does not need to meet all of the nine criteria.

This Declaration of Independent Contractor Status Form documents the business relationship as defined in the Colorado Workers' Compensation Act. *It is the responsibility of our policyholders and their independent contractor(s) to correctly and truthfully complete this form.* Pinnacol Assurance will accept this form only when it is initialed where applicable, signed, and notarized by both parties. If you do not understand this form, do not sign it.

Please make copies of this form as needed. You should complete this form only once for each independent contractor for the lifetime of your Pinnacol Assurance policy or until the business relationship changes. This form is not valid unless the notarized original form is returned to Pinnacol Assurance. Keep one copy for your records and send the notarized original to:

Pinnacol Assurance
P.O. Box 469011
Denver, CO 80246-9011

Call your Pinnacol Assurance underwriter at 303-361-4000 or 1-800-873-7242 if you have questions.

Declaration of Independent Contractor Status Form

We certify UNDER PENALTY OF PERJURY that: (name and trade name) _____
 performing (type of work) _____
 Social Security or Federal Employer Identification # _____
 Address: _____ Phone: _____
 is an independent contractor (IC) and is not an employee of the following policyholder (PH): Foothills Commercial Builders, Inc.
 Address: 14180 E. Evans Ave. Aurora 80014 Policy # 4103501 Phone: 303-765-5711 ext. 312

- We also certify, by OUR initials WHERE APPLICABLE, that the above business for which the above individual performs services meet the following criteria:
- IC _____ PH SD 1. The business DOES NOT require the individual to work ONLY for the business for whom services are performed (except that the individual may DECIDE to work only for the business for a definite period);
 - IC _____ PH SD 2. The business DOES NOT establish a quality standard for the individual (except that the business may provide plans and specifications regarding work but cannot oversee the actual work or instruct the individual as to how work will be performed);
 - IC _____ PH SD 3. The business DOES NOT pay the individual a salary or an hourly rate instead of a fixed or contract rate;
 - IC _____ PH SD 4. The business DOES NOT terminate the work or the service provided during the contract period unless the individual violates the terms of the contract or fails to produce a result that meets the specifications of the contract;
 - IC _____ PH SD 5. The business DOES NOT provide more than minimal training for the individual;
 - IC _____ PH SD 6. The business DOES NOT provide tools or benefits to the individual (except that materials and equipment may be supplied);
 - IC _____ PH SD 7. The business DOES NOT dictate the time of performance (except that a completion schedule and a range of agreeable work hours may be established);
 - IC _____ PH SD 8. The business DOES NOT pay the individual personally instead of making payment or checks payable to the trade or business name of the individual;
 - IC _____ PH SD 9. The business DOES NOT combine the business operations in any way with the individual's business operations instead of maintaining all such operations separately and distinctly.

**SIGN
HERE**

CERTIFICATION BY INDEPENDENT CONTRACTOR

THE INDEPENDENT CONTRACTOR UNDERSTANDS THAT HE/SHE:
WILL NOT BE ENTITLED TO ANY WORKERS' COMPENSATION BENEFITS IN THE EVENT OF INJURY.
IS OBLIGATED TO PAY ALL FEDERAL AND STATE INCOME TAX ON ALL MONEY EARNED WHILE PERFORMING SERVICES FOR THE BUSINESS.
IS REQUIRED TO PROVIDE WORKERS' COMPENSATION INSURANCE FOR ALL WORKERS THAT HE/SHE HIRES.

Independent Contractor Signature _____ Title _____ Social Security # _____
 STATE OF COLORADO, COUNTY OF _____
 Subscribed and sworn before me by _____ this _____ day of _____
 Commission expires: _____

NOTARY PUBLIC

* Must be notarized. Foothills has notary, as an option.*

Acceptance of the Independent Contractor named on this form does not change any party's responsibility under the Workers' Compensation Act. If individuals or organizations hired or contracted by the Independent Contractor are not covered by other workers' compensation insurance, the policyholder specified on this form will be charged premium for coverage of those individuals or organizations.

CERTIFICATION BY BUSINESS * Section to be filled out by Foothills Commercial Builders, Inc. *

I certify that I am authorized by the business listed above to state that all of the information on this form is true and accurate. I understand that if the above person does not qualify for independent contractor status, the proper premium can be assessed.

Signature _____ Title _____
 STATE OF COLORADO, COUNTY OF _____
 Subscribed and sworn before me by _____ this _____ day of _____
 Commission expires: _____

NOTARY PUBLIC

STATE OF COLORADO FORM

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

REJECTION OF COVERAGE BY PARTNERS AND SOLE PROPRIETORS PERFORMING CONSTRUCTION
WORK ON CONSTRUCTION SITES

PART A

1. Type of Entity Sole Proprietorship General Partnership (GP)
 Limited Partnership (LP)
 Limited Liability Partnership (LLP)
 Limited Liability Limited Partnership (LLLLP)

2. True Name of Business _____

3. Registered Trade Name (if applicable) _____

4. Mailing Address _____
 Street or P.O. Box, Unit/Suite _____
 City State Zip

5. Federal Employer Identification Number _____ 6. Business Phone _____

7. Date of Registration of Trade Name or Partnership _____

8. Nature of Work Performed on Construction Sites _____

9. Sole Proprietor or Partner(s) Rejecting Coverage (attach a separate sheet if necessary):

<u>Name</u>				<u>Title (e.g. Sole Proprietor, General Partner, or Limited Partner)</u>
_____	_____	_____	_____	_____
First	Middle	Last	Suffix (Jr., Sr., III)	
_____	_____	_____	_____	_____
First	Middle	Last	Suffix (Jr., Sr., III)	

10. Number of employees of the business *other* than the sole proprietor or partners listed above : _____

11. Workers' Compensation Insurance Policy Information:

a. Insurer Name N/A b. Policy Number _____

c. Effective Dates From _____ To _____

12. Submitted by:

_____	_____	_____
Name	Title	Date

C.R.S. Section 10-1-128(6)(a) states: "It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies."

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

**REJECTION OF COVERAGE BY PARTNERS AND SOLE PROPRIETORS PERFORMING CONSTRUCTION
WORK ON CONSTRUCTION SITES**

PART B

Sole Proprietor or Partner Questionnaire

1. Sole Proprietor/Partner Name _____
First Middle Last Suffix (Jr., Sr., III)

2. Title _____ 3. Business Phone _____

4A. If Sole Proprietor: Date Business Started _____

4B. If Partner: Date Became Partner _____

5. True Name of Business _____

6. Trade Name (if applicable) _____

7. Mailing Address _____
Street or P.O. Box, Unit/Suite
City State Zip

8. Mark ONE that Applies:

I hereby elect to reject workers' compensation insurance coverage based on C.R.S. § 8-41-404.
By signing this form, you are acknowledging your rejection of all benefits under the Workers' Compensation Act. The election to reject workers' compensation insurance as a sole proprietor/partner must be voluntary and cannot be a condition of your employment.

I hereby rescind my previously filed rejection of coverage.

Sole Proprietor/Partner Signature Date

9. Notary

Subscribed and sworn to be before this _____ day of _____, _____

Notary Public

SEAL

In and for _____ County

and _____ State

My commission expires _____

C.R.S. Section 10-1-128(6)(a) states: "It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies."

INSTRUCTIONS/DEFINITIONS

General Instructions: Complete all information. Type or legibly print. **A separate questionnaire, Part B, must be completed and attached for each sole proprietor/partner rejecting coverage.** Incomplete forms may not be processed and may be returned. Mail the forms by certified mail to the Division of Workers' Compensation per the below mailing instructions.

The effective date of election is the day of receipt of said notice by Division. If a sole proprietor or partner changes his/her election, a revised questionnaire must be filed.

Part A

1. **Type of Entity:** Check the appropriate box to indicate if the company is a sole proprietorship, general partnership (GP), limited partnership (LP), limited liability partnership (LLP), or a limited liability limited partnership (LLLL). Sole proprietors wishing to reject coverage must have a trade name registered with the Secretary of State pursuant to § 7-71-103, C.R.S. Partners wishing to reject coverage must be a partner in a partnership that has filed with the Secretary of State a.) a certificate of limited partnership pursuant to § 7-62-201, C.R.S., b.) a partnership registration statement pursuant to § 7-60-144 or 7-64-1002, C.R.S., or c.) a statement of trade name pursuant to § 7-71-103, C.R.S.
2. **True Name of Business:** List the legal name of the business as filed with the Secretary of State.
3. **Registered Trade Name (if applicable):** List the trade name of the business as filed with the Secretary of State.
4. **Mailing Address:** List the complete business mailing address of the business including Street or P.O. Box, Suite Number, City, State, and Zip Code.
5. **Federal Employer Identification Number:** List the Federal Employer Identification Number assigned to the corporation or LLC by the Internal Revenue Service.
6. **Business Phone:** List the telephone number of the person signing Part A of the form.
7. **Date of Registration of Trade Name or Partnership:** List the date the trade name or partnership was registered with the Secretary of State.
8. **Nature of Work Performed on Construction Sites:** Briefly describe the type or nature of construction work performed on construction sites.
9. **Sole Proprietor or Partner(s) Rejecting Coverage:** List the full name and title for the sole proprietor or partner in a partnership electing to reject workers' compensation coverage. Please include first, middle, last, and suffix if applicable. Attach separate sheet if more space is needed.
10. **Number of employees of the business other than sole proprietor or partners listed above:** List the number of employees other than the sole proprietor or partners listed under #9. Any person who is an employee of the business who is not a sole proprietor or a partner in a partnership electing to reject coverage **must** be insured for workers' compensation.
11. **Workers' Compensation Insurance Policy Information:** List the name of the insurance carrier (insurer), the complete current policy number, and the effective dates of the current policy.
12. **Submitted by:** Type or legibly write the name and title of the individual submitting the form on behalf of the business, and the date the form was completed.

Part B, Sole Proprietor or Partner Questionnaire

To be completed by the sole proprietor or *each* partner electing to reject workers' compensation insurance coverage or rescinding a previous election.

1. **Sole Proprietor or Partner Name:** List the full name of the sole proprietor or individual partner completing Part B. Please include first, middle, last, and suffix if applicable.
2. **Title:** List the title of the sole proprietor or individual partner completing Part B.
3. **Business Phone:** List the business telephone number of the sole proprietor or individual partner completing Part B.
- 4A. **If Sole Proprietor, Date Business Started:** List the date the sole proprietor began business operations in Colorado.
- 4B. **If Partner, Date Became Partner:** List the date the individual completing Part B became a partner in the partnership.
5. **True Name of Business:** List the legal name of the business as filed with the Secretary of State.
6. **Trade Name (if applicable):** List the trade name of the business as filed with the Secretary of State.
7. **Mailing Address:** List the complete business mailing address of the business including Street or P.O. Box, Suite Number, City, State, and Zip Code.
8. **Mark ONE that Applies:** Check the appropriate box to indicate if the sole proprietor or individual partner completing Part B is rejecting worker's compensation coverage or rescinding a previously filed rejection of coverage. The individual rejecting coverage or rescinding coverage **must** sign and date Part B. If the rescinding option is selected, Part A need not be completed.
9. **Notary:** The signature of the sole proprietor or individual partner completing Part B must be notarized.

Mailing Instructions

File this form by certified mail with the Division of Workers' Compensation at the following address:

Division of Workers' Compensation
Coverage Enforcement Unit
633 17th St., Suite 400
Denver, CO 80202-3660
303.318.8700

COLORADO DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

REJECTION OF COVERAGE BY CORPORATE OFFICERS OR MEMBERS OF A LIMITED
LIABILITY COMPANY (LLC)

PART B - Corporate Officer or LLC Member Questionnaire

IMPORTANT: A separate Part B MUST be completed by every person listed in Part A.

1. Name of Corporation or LLC _____
2. Mailing Address _____
Street or P.O. Box, Unit/Suite _____
City _____ State _____ Zip _____
3. Officer or Member Name _____
First _____ Middle _____ Last _____ Suffix (Jr., Sr., III) _____
4. Corporate Officer Title _____ 5. Business Phone _____
6. Date Officer/Member Elected _____
7. Duties performed for Corporation or LLC _____

8. Mark ONE that Applies:

- I hereby elect to reject workers' compensation insurance coverage based on C.R.S. 8-41-202 (Non-agricultural).
By signing this form, you are acknowledging your rejection of all benefits under the Workers' Compensation Act. You are further acknowledging that you are an owner of at least 10% of the stock of the corporation or at least 10% of the membership interest of the LLC at all times, and control, supervise or manage the business affairs of the corporation or LLC. The election to reject workers' compensation insurance as a corporate officer/LLC member must be voluntary and cannot be a condition of your employment.
- I hereby rescind my previously filed rejection of coverage.

Corporate Officer/LLC Member Signature _____ Date _____

9. Notary

Subscribed and sworn to be before this _____ day of _____,

Notary Public

SEAL

In and for _____ County

and _____ State

My commission expires _____

C.R.S. Section 10-1-128(6)(a) states: "It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies."

INSTRUCTIONS/DEFINITIONS

General Instructions: Complete all information. Type or legibly print. **A separate questionnaire, Part B, must be completed and attached for each officer/member rejecting coverage.** Incomplete forms may not be processed and may be returned. Mail the forms by certified mail to the insurance carrier *or* the Division of Workers' Compensation per the below mailing instructions.

The effective date of election is the day following receipt of said notice by the insurance carrier or the Division. If an officer or limited liability company member changes his/her election, a revised questionnaire must be filed.

Part A

1. **Type of Entity:** Check the appropriate box to indicate if the company is a corporation or a limited liability company (LLC).
2. **Name of Corporation or LLC:** List the legal name of the corporation or LLC as filed with the Secretary of State.
3. **Mailing Address:** List the complete business mailing address of the corporation or LLC including Street or P.O. Box, Suite Number, City, State, and Zip Code.
4. **Nature of Business:** Briefly describe the type and nature of business conducted by the corporation or LLC.
5. **Federal Employer Identification Number:** List the 9-digit Federal Employer Identification Number assigned to the corporation or LLC by the Internal Revenue Service.
6. **Business Phone:** List the telephone number of the Corporate Secretary or LLC Manager signing Part A of the form.
7. **Date of Incorporation or Organization:** List the date of incorporation for a corporation or the date of filing of Articles of Organization for an LLC.
8. **State of Incorporation or Organization:** List the state where the corporation is incorporated or where the LLC filed its Articles of Organization.
9. **Corporate Officers or LLC Members Rejecting Coverage:** List the full name of the person(s) rejecting coverage. Please include first, middle, last, and suffix (if applicable). Include title or titles, and the percent of corporate ownership or membership interest in the company for each corporate officer or LLC member electing to reject workers' compensation coverage. Under C.R.S. §8-41-202(4), "corporate officer" means "the chairperson of the board, president, vice-president, secretary, or treasurer who is an owner of at least ten percent of the stock of the corporation and who controls, supervises or manages the business affairs of the corporation, as attested to by the secretary of the corporation at the time of the election." LLC members must own at least 10% of the membership interest in the company at all times and control, supervise or manage the business affairs of the limited liability company to be eligible to reject coverage. Attach separate sheet if more space is needed.
10. **Number of employees of the corporation or LLC other than officers or members listed above:** List the number of employees other than officers or members listed under #9. Any person who is an employee of the corporation or LLC, who is not a corporate officer or LLC member electing to reject coverage, **must** be insured for workers' compensation.
- 11A. **Does your company have workers' compensation insurance?** Place a check in the appropriate space indicating whether the business has Workers' Compensation insurance.
- 11B. **If "Yes" to Question 11A, provide Workers' Compensation insurance policy information:** If your business has Workers' Compensation insurance, list the name of the insurance carrier (insurer), the complete current policy number, and the effective dates of the current policy.
12. **Certification:** Only the Corporate Secretary or LLC Manager **shall** sign and date Part A certifying that the information contained on the form is correct and complete. If a Corporate Secretary has not been named, the President may sign in lieu of the Corporate Secretary. Type or legibly write the name of the Corporate Secretary or LLC Manager and the name of the corporation or LLC.

Part B. Corporate Officer or LLC Member Questionnaire

To be completed by *each* Officer or Member electing to reject workers' compensation insurance coverage or rescinding a previous election.

- 1. Name of Corporation or LLC:** List the legal name of the corporation or LLC as filed with the Secretary of State.
- 2. Mailing Address:** List the complete business mailing address of the corporation or LLC including Street or P.O. Box, Suite Number, City, State, and Zip Code.
- 3. Officer or Member Name:** List the name of the individual corporate officer or LLC member completing Part B. List the full name of the person rejecting coverage. Please include first, middle, last, and suffix (if applicable).
- 4. Corporate Officer Title:** List the title of the individual corporate officer completing Part B. If an LLC member is completing Part B, leave blank.
- 5. Business Phone:** List the business telephone number of the individual corporate officer or LLC member completing Part B.
- 6. Date Officer/Member Elected:** List the date the individual corporate officer or LLC member completing Part B was elected to the position.
- 7. Duties performed for Corporation or LLC:** Briefly describe the *specific* duties performed for the corporation or LLC by the individual corporate officer or LLC member completing Part B.
- 8. Mark ONE that Applies:** Check the appropriate box to indicate if the individual corporate officer or LLC member completing Part B is rejecting worker's compensation coverage or rescinding a previously filed rejection of coverage. The individual rejecting coverage or rescinding coverage **must** sign and date Part B. If the rescinding option is selected, Part A need not be completed.
- 9. Notary:** The signature of the individual corporate officer or LLC member completing Part B must be notarized.

Mailing Instructions

Insured: If the corporation or LLC has a workers' compensation insurance carrier, file this form by certified mail directly with your insurance carrier.

Noninsured: If there is no workers' compensation insurance carrier, file this form by certified mail with the Division of Workers' Compensation at the following address:

Division of Workers' Compensation
Coverage Enforcement Unit
633 17th St., Suite 400
Denver, CO 80202-3660
303.318.8700