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 (LLLP)

NOTE: Sole Proprietors and General Partnerships MUST have a TRADE NAME registered with the Colorado Secretary of State.

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. Email Address: _____

6. Federal Employer Identification Number: _____ 7. Business Phone: _____

8. Date of Registration of Trade Name or Partnership: _____

9. Nature of Work Performed on Construction Sites: _____

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

Name				Title (e.g. Sole Proprietor, General Partner, or Limited Partner
First	*Middle*	*Last*	*Suffix (Jr., Sr., III)*	

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

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."**

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PART B - Sole Proprietor or Partner Questionnaire

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

1. Sole Proprietor/Partner Name: _____ _____ _____ _____
First Middle Last Suffix

2. Title (e.g. Sole Proprietor, General Partner, or Limited Partner): _____ 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 and that if you are hurt on the job, C.R.S. § 8-41-401(3) may limit your recovery to $15,000. 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

The person who signs this form swears and attests that he or she is the person named within. Pursuant to Section 18-5-102, C.R.S., any person who, with the intent to defraud, falsely completes or alters a written instrument officially issued or created by a public office, public servant, or government agency has committed forgery, a class 5 felony, and shall be subject to punishment as provided in Section 18-1.3-401, C.R.S.

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. Submit the forms to the insurance carrier or the Division of Workers' Compensation per the below submission 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 (LLLP). 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 Colorado Secretary of State. Sole proprietorships and general partnerships MUST have a trade name registered with the Colorado Secretary of State in order to be eligible to reject coverage.

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.

6. **Federal Employer Identification Number:** List the 9-digit Federal Employer Identification Number assigned to the business by the Internal Revenue Service.

7. **Business Phone:** List the telephone number of the person signing Part A of the form.

8. **Date of Registration of Trade Name or Partnership:** List the date the trade name or partnership was registered with the Secretary of State.

9. **Nature of Work Performed on Construction Sites:** Briefly describe the type or nature of construction work performed on construction sites.

10. **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.

11. **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.

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.

Submission Instructions

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

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

Division of Workers' Compensation
Coverage Enforcement Unit
633 17th St., Suite 400
Denver, CO 80202-3626
303.318.8700

OR by e-mail to:

cdle_dowc_coverage@state.co.us

This is a **temporary** version of WC45, intended to assist in the submission process during the COVID-19 outbreak. (3/20/2020)