APPLICATION FOR WAIVER

STATE OF MAINE
WORKERS' COMPENSATION BOARD
27 STATE HOUSE STATION, AUGUSTA, MAINE 04333-0027
TEL: (207) 287-3751 FAX: (207) 287-5413

WAIVERS ARE NOT VALID UNTIL APPROVED BY THE BOARD

APPLICANT-EMPLOYEE

NAME: _____

STREET: _____

CITY, STATE, ZIP: _____

APPLICANT PHONE #: _____

BUSINESS - EMPLOYER

NAME: _____

STREET: _____

CITY, STATE, ZIP: _____

EMPLOYER PHONE #: _____

EMPLOYER FEIN #: _____

I am employed by the above-named employer which is a (check one):

- ☐ SOLE PROPRIETOR
- ☐ PARTNERSHIP
- ☐ LIMITED LIABILITY COMPANY
- ☐ CORPORATION/S-CORP
- ☐ PROFESSIONAL CORPORATION

And (select the correct option under I, II or III):

I. ☐ The **Applicant** is the (**check one):** ☐ **PARENT** ☐ **SPOUSE** ☐ **DOMESTIC PARTNER** ☐ **CHILD** of the above-named Sole Proprietor, or Partner or Member of a Limited Liability Company.

II. The **Applicant** is the **(check one)** ☐ bona fide owner of at least 20% of the outstanding voting stock of the above-named corporation **OR** ☐ the (**check one):** ☐ **PARENT** ☐ **SPOUSE** ☐ **DOMESTIC PARTNER** ☐ **CHILD** of a bona fide owner.

- Number of Voting Stock **Issued** by Employer _____ (actual number—not percentage)
- Number of Voting Stock **Owned** by Applicant _____(actual number—not percentage)

III. The **Applicant** is a (**check one)**

☐ shareholder of the above-named professional corporation **OR**

☐ the **(check one):** ☐ PARENT ☐ SPOUSE ☐ DOMESTIC PARTNER ☐ CHILD of a shareholder of the above-named professional corporation.

I hereby waive all benefits and privileges provided by the Maine Workers' Compensation Act pursuant to 39-A M.R.S.A. §102(11) (A) (4) and (5). I certify that the foregoing information is truthful and accurate, and that this waiver is not a prerequisite condition to employment. I understand that if this information is found to be intentionally misleading or fraudulent, or if the information changes, this waiver may be nullified. I agree to notify the Workers' Compensation Board of any changes in this information.

_____ _____

APPLICANT SIGNATURE DATE

NOTE: ANY PERSON MAY REVOKE OR RESCIND THAT PERSON'S WAIVER UPON 30 DAYS WRITTEN NOTICE TO THE BOARD AND THAT PERSON'S EMPLOYER.

The State of Maine provides equal opportunity in employment and programs. Auxiliary aids and services are available to individuals with disabilities upon request. For assistance with this form, contact the ADA Coordinator at the Maine Workers' Compensation Board. Telephone: (888) 801-9087 or TTY Maine Relay 711.