# WORKERS' COMPENSATION COMMISSION

## SOLE PROPRIETOR'S STATUS AS A COVERED EMPLOYEE FORM

I hereby represent to the Maryland Workers' Compensation Commission that I am a sole proprietor doing business in and about the State of Maryland, and that on the date set forth below my signature, under the penalty of perjury, the following checked box represents my status as a covered employee.

**Check all that apply:**

☐ I have elected to become a covered employee under § 9-227 of the Labor and Employment Article, Annotated Code of Maryland, and have submitted the requisite Inclusion form (IC-15R) with the Workers' Compensation Commission.

☐ I have not elected to become a covered employee under § 9-227 of the Labor and Employment Article, Annotated Code of Maryland.

I understand that if I were to hire an employee(s), I must obtain workers' compensation insurance for the employee(s).

Name of Sole Proprietor: _____

Social Security Number or Federal
Employer Identification Number (FEIN) _____

Address: _____
Street

_____ _____ _____
City State Zip Code

**I AFFIRM UNDER THE PENALTY OF PERJURY THAT THE FOREGOING INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE, INFORMATION AND BELIEF FOR THE FOLLOWING PERIOD:**

_____ **THROUGH** _____ .
**(Effective date)** **(Expiration date)**

_____ _____
Signature Date

**10 East Baltimore Street • Baltimore, Maryland 21202-1641**

**410-864-5100 • Email: info@wcc.state.md.us • Web: http://www.wcc.state.md.us**



CLICK HERE TO CLEAR THE FORM