



# NOTICE FOR WORKER'S COMPENSATION AND OCCUPATIONAL DISEASES COVERAGE

State Form 36097 (R5 / 9-11)

**INDIANA WORKER'S COMPENSATION BOARD**  
402 W Washington Street, Room W196  
Indianapolis, IN 46204

*INSTRUCTIONS: Please type or print. Incomplete or illegible forms will be returned. For current forms, go to [www.in.gov/wcb](http://www.in.gov/wcb).*

Pursuant to IC 22-3-6-1(b) and 22-3-2-9, the Indiana Worker's Compensation Board is hereby notified that the undersigned applicant does hereby elect to be covered for worker's compensation and occupational diseases under the law.

### STATEMENT OF VOLUNTARY ELECTION [IC 22-3-6-1(b)]

Name of applicant		Federal Identification number (not Social Security number)
Address (number and street, city, state, and ZIP code)		
I certify that I meet the criteria set out in IC 22-3-6-1 (b) (4), (5) or (9), as selected below: <input type="checkbox"/> (4) Sole Proprietor <input type="checkbox"/> (5) Partner <input type="checkbox"/> (9) Member or Manager of a Limited Liability Company		
Name of business		Nature of business
Address (number and street, city, state, and ZIP code)		
Name of Insurance carrier		Telephone number (    )
Address (number and street, city, state, and ZIP code)		
I certify that I am actually and actively engaged in said business		<input type="checkbox"/> I, the undersigned, do elect to be covered by the Worker's Compensation and Occupational Diseases coverage until I file a request for cancellation of this election.
Signature of applicant	Printed name	Date signed (month, day, year)

### STATEMENT OF VOLUNTARY ELECTION [IC 22-3-2-9]

<b>FOR:</b> <input type="checkbox"/> Farm or Agricultural Employees <input type="checkbox"/> Household Employees <input type="checkbox"/> Part-time Volunteer Coaches for non-profit corporation <input type="checkbox"/> Casual Laborers		
The undersigned hereby voluntarily elects to be bound by the provisions of the Indiana Worker's Compensation and Occupational Diseases acts. I understand that I elect to be covered until I file a request for cancellation of this election.		
Type of business <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> LLC <input type="checkbox"/> Other _____		
Name of Insurance carrier		Telephone number (    )
Address (number and street, city, state, and ZIP code)		
Name of Employer		Federal Identification number (not Social Security number) Telephone number (    )
Address (number and street, city, state, and ZIP code)		
Signature of Employer	Printed name	Date signed (month, day, year)
Name of Agent		Telephone number (    )
E-mail address		