

State of Montana Department of Labor and Industry
Independent Contractor Exemption Certificate Application
for Corporate Officers and Manager-Managed Limited Liability Companies

WAIVER of Workers' Compensation Benefits

Instructions: Sign this waiver only if you understand and agree to all of its provisions.

Name: _____ Social Security Number: _____
(Last) (First) (Middle)

I, _____, am executing this waiver in order to apply for an independent contractor exemption certificate with the Montana Department of Labor and Industry (Department).

Please **initial** all the following statements if you understand and agree:

(Initial) I understand and agree that as a qualifying corporate officer or qualifying manager of a manager managed liability company (LLC) who directly owns or, when aggregated with qualifying relatives, owns 20% or more of the shares of a corporation or LLC, I am exempt from the requirement to obtain workers' compensation coverage on myself under the Montana Workers' Compensation Act of Montana, Title 39, Chapter 71, MCA (Act). I also understand that I can voluntarily choose to obtain workers' compensation coverage on myself under the Act and would then be entitled to all the benefits under the Act. **However, by applying for an independent contractor exemption certificate, I agree to waive all my rights to obtain the coverage benefits for which I may be eligible under the Act, for any work performed under the certificate.** I understand and agree that if I am injured or develop an occupational disease while working for a hiring agent, I am precluded from obtaining any benefits under the Act for any and all damages arising out of any injury or occupational disease related to my work performance under an independent contractor exemption certificate. I understand and agree that if I die from an injury or occupational disease related to my work performance under an independent contractor exemption certificate, this waiver is effective against any of my beneficiaries as designated under the Act. I understand this waiver is not necessary for workers' compensation purposes if I elect to obtain workers' compensation insurance for myself as provided by the Act.

(Initial) I understand and agree that if my independent contractor exemption certificate is granted, I will be conclusively presumed in court to have waived all benefits under the Act for work performed under the certificate.

(Initial) I am engaged in an independently established trade(s), occupation(s), or profession(s) (occupation(s) related to the qualifying corporation or LLC that I hold a position with and I have provided accurate and truthful documentation to the Department to verify the existence of this occupation(s) in my affidavit application.

(Initial) When acting as an independent contractor, I agree to maintain my status as an independent contractor by being free from control or direction over the performance of my services and the details of my work, both under contract and in fact. I agree hiring agents will only be permitted to offer direction and exercise control in matters essential to specifying the end result. I understand that while performing work under my independent contractor exemption certificate that I am waiving potential benefits under the Act unless I have a written or oral agreement to work as an employee for that hiring agent.

(Initial) I understand and agree that I am responsible for all taxes related to my work as an independent contractor, including unemployment insurance taxes.

(Initial) I understand the Department has the authority to investigate my working relationships as an independent contractor and may suspend or revoke my independent contractor exemption certificate if appropriate.

(Initial) I am of sound mind, I am 18 years of age or older, I have read and understand this waiver, and I am voluntarily and knowingly executing this waiver free from duress, coercion, or misrepresentation from any person.

By signing this waiver, I understand and agree that I WAIVE ALL STATUTORY RIGHTS AND BENEFITS THAT I MAY BE ELIGIBLE FOR UNDER THE ACT, if I chose to obtain coverage on myself.

By: _____
(Applicant signature)

Dated: _____

State of _____)
County of _____) SS

SUBSCRIBED before me this ____ day of _____, 20____.

(Signature of Notary Public)

(Printed Name of Notary Public)

(Notarial seal)

Residing at _____

My commission expires _____