pennsylvania
DEPARTMENT OF LABOR & INDUSTRY
STATE WORKERS' INSURANCE FUND

VOLUNTARY ELECTION OF COVERAGE

Sole Proprietors, Partners of a Partnership or Members of an LLC electing to be covered under the Pennsylvania Workers' Compensation Act must complete this Election of Coverage Form. Premium will be based on total payroll, subject to the same minimum and maximum payroll as an executive officer, $28,600 (minimum) to $114,400 (maximum) per year. This will be subject to review at audit time by copies of the net self employment earnings form for a sole proprietor, corporate tax return for LLCs and Form 1065 for partners. The minimum payroll figure is the smallest payroll amount SWIF can use for the policy but the policy will be based on actual payroll should the actual payroll be higher than $28,600.

In the event a claim is submitted under Sections 306 or 307 of the Pennsylvania Workers' Compensation Act, the payroll reported at the time of application or during a subsequent audit will be considered as part of the Average Weekly Wage calculation.

All Voluntary Elections of Coverage will be in effect for the **full policy period** and will remain in effect for each policy renewal until the State Workers' Insurance Fund is provided written notification to the contrary. You must select one of the business types below that describes your business entity. **Do not make a selection if you are declining coverage**. Each Partner and/or Member must complete one of these forms. **Coverage will not be added or deleted during the policy term.**

BE ADVISED THIS FORM IS NOT FOR EMPLOYEES AND, IF COMPLETED BY THE OWNER, CANNOT BE VOIDED UNTIL THE FOLLOWING RENEWAL

☐ I, the below named Sole Proprietor, do hereby knowingly and voluntarily elect to be an employee of the below named business for purposes of the Pennsylvania Workers' Compensation Act.

☐ I, the below named Partner, do hereby knowingly and voluntarily elect to be an employee of the below named business for purposes of the Pennsylvania Workers' Compensation Act.

☐ I, the below named Member of an LLC, do hereby knowingly and voluntarily elect to be an employee of the below named business for purposes of the Pennsylvania Workers' Compensation Act.

NOTE: Your Voluntary Election of Coverage, by law, applies to all businesses covered under this policy.

Job Description of Owner to be Included: _____

_____

Social Security Number: _____

Business's Full Legal Name: _____

Address: _____ Phone: _____

City, State, Zip: _____

Policy/Quote Number: _____ Policy/Quote Effective Date: _____

☐ **Electing Coverage at this time** ☐ **Declining Coverage at this time**

I verify that the facts set forth in this Election of Coverage are true and correct to the best of my knowledge, information and belief. This verification is made subject to the penalties of 18 Pa.C.S § 4904, relating to unsworn falsification to authorities.

Signature of Owner: _____ **Payroll:** _____ **Date:** _____

Print Name of Signature: _____