

## Certification of Compliance with the Minnesota Workers' Compensation Law

PRINT IN INK or TYPE

NAME (last name, first name, middle name)	DOING BUSINESS AS (full business name if different than your name)		
FEDERAL EMPLOYER ID NO.	STATE ID NO.		
STREET ADDRESS	CITY	STATE	ZIP CODE
BUSINESS TELEPHONE NO.	HOME TELEPHONE NO.		
TYPE OF BUSINESS (Examples, Bldg. Construction, or Logging, or Manufacturing)			
WORKERS' COMPENSATION INSURANCE COMPANY (NOT insurance agent)			
POLICY NO. (full number from insurance policy)	DATES OF COVERAGE (from)	THROUGH (ending date)	

OR ( IF EXEMPT )

I certify that I am not required to carry workers' compensation insurance because (check one)

I am a sole proprietor and I have no employees (See Minn. Stat. 176.011, subd. 9)

I have no employees who are covered by the workers' compensation law.

(Only employees who are specifically exempted by statute are not covered by the workers' compensation law. These include: Spouse; Parents; Children, regardless of age; and farm labor employees of a family farm that spent less than \$8,000 for farm labor in the previous calendar year. All other workers whose work activity is controlled by the employer must be covered.) See Minn. Stat. 176.041 for a list of excluded employees.

Explain why your employees are not covered: \_\_\_\_\_

I understand that the information provided above will be verified by the Minnesota Department of Labor and Industry. I understand that I am subject to a \$1,000 penalty if the information is false.

I certify that the information provided above is accurate and complete.

SIGNATURE	DATE
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