



Fund Member: COUNTY OF MECOSTA Policy Year: _____

TO BE COMPLETED BY THE INDEPENDENT CONTRACTOR

Subcontractor Name: _____

Doing Business as (DBA): _____

1. I operate as: Sole Proprietor Partnership Corporation Limited Liability Company

Note: If indicating Partnership, Corporation, or Limited Liability Company, a Certificate of Workers' Compensation insurance or a properly filed BWC 337 form must be submitted.

2. The type of work I performed can be described as: _____

3. I hire employees or casual laborers to complete work for the named policyholder:

- Yes You must attach a certificate of Workers Compensation Insurance
- No Form 1040 schedule C may be provided as verification

4. I hire subcontractors or casual laborers to complete work for the named policy holder: Yes No

5. I have General Liability and/or Professional Liability Coverage: Yes No

6. To validate my standing as an independent contractor, I state that I do not exclusively depend upon the payments of the named policyholder and have worked for the following general contractors or clients during the past twelve months.

Name	City	Phone
1. _____		
2. _____		
3. _____		

I acknowledge that as a sole proprietor, I am by law not covered by or subject to the Workers' Disability Compensation Act.

I certify the above represent a true and complete statement of my status as an Independent Contractor. I understand a company representative may verify that statement at any time. If requested, I agree to provide documentation to verify my status as a sole proprietor.

Signed _____ Date: _____
(Independent Contractor)

Phone Number: _____ Email Address: _____
(Required)

This form is utilized as a test of the above individual's independent status. By completing this form, it does not automatically remove the above individual's exposure from the audit of the policy period in question. **Additional information may be required.** If independent status is proven, the exposure will not be charged.