Workers' Compensation Acknowledgement

Employer & Worker Information

EIN Holder/Employer: _____
Worker Name: _____
Relationship to EIN Holder (Employer): ☐ Spouse ☐ Parent ☐ Child ☐ Other

Worker's compensation coverage is required for workers who are not the spouse, parent, or child of the EIN holder.

Choose one:

☐ **I am** the spouse/parent/child of the employer listed above, and **I wish to waive** workers compensation coverage.

☐ **I am** the spouse/parent/child of the employer listed above, and **I do not want to waive** workers compensation coverage.

☐ **I am not** the spouse/parent/child of the employer listed above and **coverage is required.**

Reason for Exclusion (Required Disclosure)

Workers' compensation coverage does not apply to: "A sole proprietor, or the spouse, parent, and child, regardless of age, of a sole proprietor." The Minnesota Department of Labor & Industry confirms that sole proprietors and their immediate family members are excluded from mandatory workers' compensation coverage.

Acknowledgements by Family Member (Worker)

By signing below, I acknowledge and agree that:

_____ I am the spouse/parent/child of the employer listed above.
_____ I understand that **I am excluded** from mandatory workers' compensation coverage under Minnesota law.
_____ If I suffer a work-related injury or illness, **I will not have workers' compensation benefits**, including:

- Medical treatment coverage
- Wage-loss benefits
- Permanent disability benefits
- Vocational rehabilitation services

_____ I have been given the opportunity to ask questions before signing.
_____ I understand that I may request the Employer to **elect to provide** workers' compensation coverage for me (optional), and that such coverage:

- Requires the business to notify its workers' compensation insurer
- If coverage is requested, the employer must submit an Election of Coverage form for workers' compensation. Coverage will not be in effect until the application has been reviewed and approved. This process may take up to four weeks, and the worker will not be covered during that time. Coverage will resume at the beginning of a pay period.

_____ I understand that this form does not waive rights for any individuals **who are not legally exempt**.

Signatures

Worker Signature: _____
Date: _____

Employer/Authorized Representative: _____
Date: _____

Internal Use (Mains'l/Fiscal Employer Agent)
☐ Verified statutory relationship
☐ Maintained in employee personnel records

Business Structure: Sole Proprietorship