SOLE PROPRIETOR STATEMENT

1. Insur Co:_____ Policy Period _____ Policy Number_____

2. Sole Proprietor _____

Business Name (DBA) _____

Address _____

The purpose of this form is to document that the above individual is a sole proprietor without employees and not subject to the Workers' Disability Compensation Act.

- I am a sole proprietorship. As such, I am not a corporation, partnership or limited liability company.
- As a sole proprietorship, I do not hire any employees, casual labor, or subcontractors with employees.
- I pay my own business operational expenses.
- I acknowledge that as a sole proprietorship without employees, I am by law not covered by or subject to the Workers' Disability Compensation Act.
- If I am an owner/operator, I am the owner and sole operator of the truck used.
- If any of the above should change, I will notify you prior to performing the next job.
- If requested, I agree to provide documentation to verify my status as a sole proprietorship without employees.

My signature on this document confirms that the above statements are true.

3. _____ _____

Signature of Sole Proprietor Date

Note: This form should be reviewed periodically for changes in the Sole Proprietor status.