PART B, SOLE PROPRIETOR OR PARTNER QUESTIONNAIRE

To be completed by the sole proprietor or each partner electing to reject workers' compensation insurance coverage or rescinding a previous election.

1. **Sole Proprietor or Partner Name:** List the full name of the sole proprietor or individual partner completing Part B. Please include first, middle, last, and suffix if applicable.

2. **Title:** List the title of the sole proprietor or individual partner completing Part B.

3. **Business Phone:** List the business telephone number of the sole proprietor or individual partner completing Part B.

4A. **If Sole Proprietor, Date Business Started:** List the date the sole proprietor began business operations in Colorado.

4B. **If Partner, Date Became Partner:** List the date the individual completing Part B became a partner in the partnership.

5. **True Name of Business:** List the legal name of the business as filed with the Secretary of State.

6. **Trade Name (if applicable):** List the trade name of the business as filed with the Secretary of State.

7. **Mailing Address:** List the complete business mailing address of the business including Street or P.O. Box, Suite Number, City, State, and Zip Code.

8. **Mark ONE that Applies:** Check the appropriate box to indicate if the sole proprietor or individual partner completing Part B is rejecting worker's compensation coverage or rescinding a previously filed rejection of coverage. The individual rejecting coverage or rescinding coverage must sign and date Part B. If the rescinding option is selected, Part A need not be completed.

9. **Notary:** The signature of the sole proprietor or individual partner completing Part B must be notarized.

MAILING INSTRUCTIONS

File this form by certified mail with the Division of Workers' Compensation at the following address:

Division of Workers' Compensation
Coverage Enforcement Unit
633 17th St., Suite 400
Denver, CO 80202-3626
303.318.8700