Instructions for Completing the

Exclusion of Uncompensated Officials

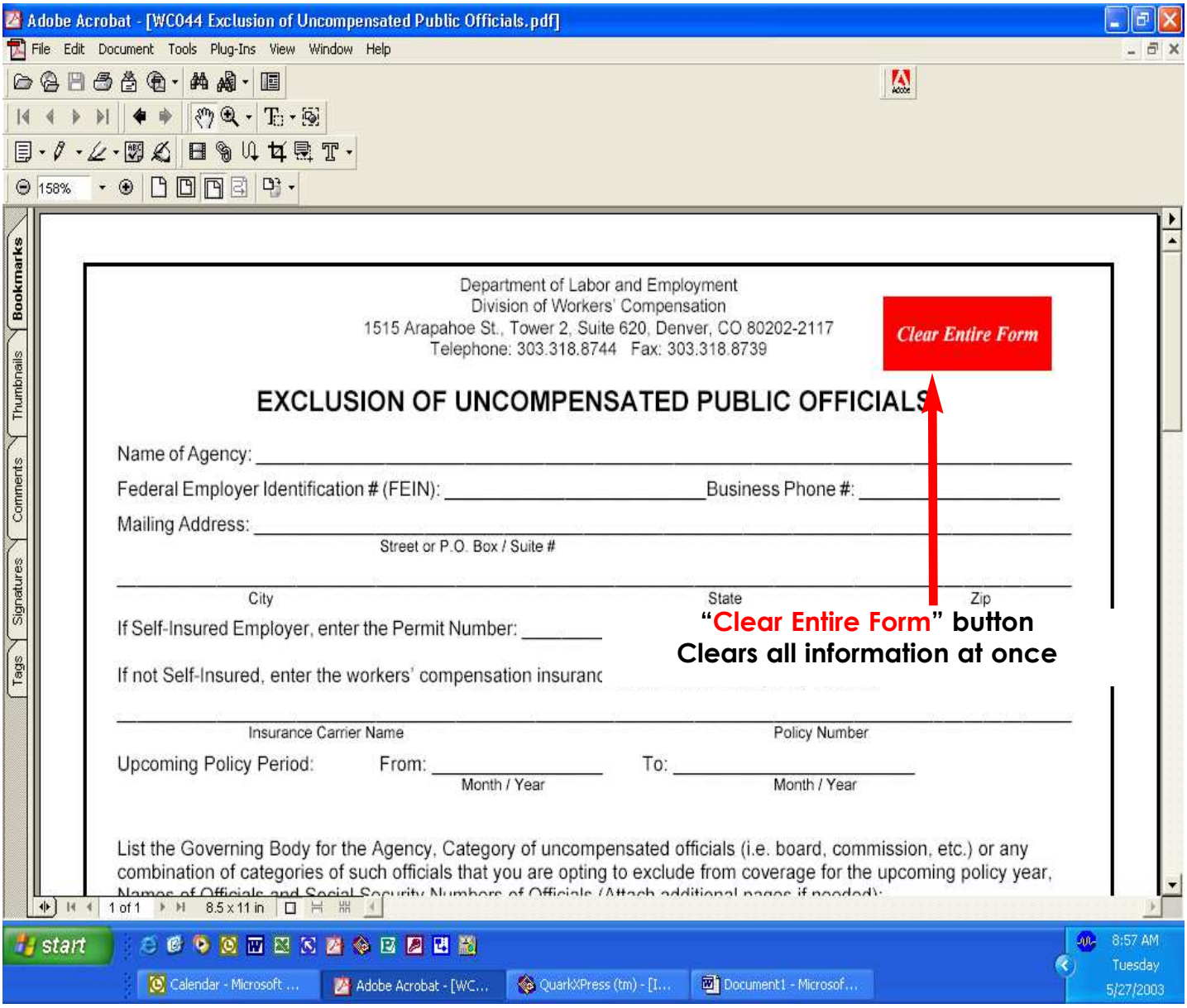
Please read all pages

This form is "fillable." That means you can type the information onto the form from your computer and print the form. You will *not* be able to save the form onto your computer's hard drive.

When you open the form, click in the "Name of Agency" box (field), and use the tab key to navigate to the next field. Do not use the Enter key; pressing the Enter key will only page down. Each field has been *limited*. This means that you *cannot* continue to type information into a field if it doesn't fit into the space provided.

Use numbers *only* to fill in the fields for Official's Social Security # and Business Phone #. Do not use dashes or parentheses; when you tab out of the field, it will fill in automatically.

To clear or delete all the information you have typed onto the form, click on the red "Clear Entire Form" button. o change the information in a single field, use the backspace or delete key.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Department of Labor and Employment
Division of Workers' Compensation
1515 Arapahoe St., Tower 2, Suite 620, Denver, CO 80202-2117
Telephone: 303.318.8744 Fax: 303.318.8739
Clear Entire Form
EXCLUSION OF UNCOMPENSATED PUBLIC OFFICIALS
Name of Agency:
Federal Employer Identification # (FEIN):
Business Phone #:
Mailing Address:
Street or P.O. Box / Suite #
City
State
Zip
If Self-Insured Employer, enter the Permit Number:
If not Self-Insured, enter the workers' compensation insuranc
Insurance Carrier Name
Policy Number
Upcoming Policy Period:
From:
Month / Year
To:
Month / Year
List the Governing Body for the Agency, Category of uncompensated officials (i.e. board, commission, etc.) or any combination of categories of such officials that you are opting to exclude from coverage for the upcoming policy year,
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Tuesday
5/27/2003

Department of Labor and Employment
Division of Workers' Compensation
633 17th Street, Suite 400, Denver, CO 80202-3626
Telephone: 303.318.8640 Fax: 303.318.8739

EXCLUSION OF UNCOMPENSATED PUBLIC OFFICIALS

Name of Agency: _____

Federal Employer Identification # (FEIN): _____ Business Phone #: _____

Mailing Address: _____
Street or P.O. Box / Suite #

_____
City State Zip

If Self-Insured Employer, enter the Permit Number: _____

If not Self-Insured, enter the workers' compensation insurance carrier name and policy number:

_____
Insurance Carrier Name Policy Number

Upcoming Policy Period: From: _____ To: _____
Month / Year Month / Year

List the Governing Body for the Agency, Category of uncompensated officials (i.e. board, commission, etc.) or any combination of categories of such officials that you are opting to exclude from coverage for the upcoming policy year, Names of Officials and Social Security Numbers of Officials (Attach additional pages if needed):

Name of Governing Body: _____

Category	Name of Official	Official's Social Security #
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

C.R.S. section 8-40-202(1)(a)(I)(B) provides an option to exclude from workers' compensation insurance coverage uncompensated elected or appointed officials. You must promptly notify each official of your exercise of the option to exclude them. This form must be filed with the Division of Workers' Compensation not less than forty-five (45) days before the start of the policy period for which the option is to be exercised. Attach governing body's resolution.

By signing this form, you are certifying that the above-named uncompensated, elected or appointed public officials are designated to be excluded from worker's compensation coverage for the upcoming policy year, pursuant to C.R.S. section 8-40-202(1)(a)(I)(B). You are also certifying that these officials have been notified of this exclusion.

Signature: _____

Print Name: _____

Date: _____ Title: _____

Submit this form with the Governing Body's Resolution to: Division of Workers' Compensation, Coverage Enforcement Unit, 633 17th Street, Suite 400, Denver, Colorado 80202-3626. If insured, please make a copy of this completed form and send it to your insurance carrier. If you have any questions, contact the Division of Workers' Compensation Customer Service Unit at 303.318.8700.

C.R.S. section 10-1-128(6)(a) states: " **It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies."**