

# NOTICE OF ELECTION TO BE EXEMPT

**Please refer to the written instructions prepared by the  
Division of Workers' Compensation before completing this form.**

By filing this application, you elect to be exempt from the provisions of Chapter 440, Florida Statutes and waive any right you may have to workers' compensation benefits in the State of Florida should you become injured on the job. Any person who knowingly and with intent to injure defraud or deceive the Division or any employer, employee, or insurance company or purposes program, files a Notice of Election to be Exempt containing any false or misleading information is guilty of a felony of the third degree. Certain documentation is required by law to be attached to this application - refer to the instruction sheet for more details.

STATE USE ONLY
Effective/Issue Date:
Expiration Date:
Control Number:
Postmark Date:
Received Date:

I am applying for exemption as a (check only one box in this section):  
**CONSTRUCTION INDUSTRY**  Sole Proprietor  Partner  Corporate Officer (your corp. title: \_\_\_\_\_) -  
**OR-**

**NON-CONSTRUCTION INDUSTRY**  Corporate Officer (your core. title: \_\_\_\_\_)

**CORPORATE OFFICERS AND PARTNERS:** List the registration number of your business on file with the Division of Corporations, Department of State's Office (NOTE: your partnership may not have one, but all corporations must have one. If your partnership doesn't have one, state "N/A"):  
 \_\_\_\_\_

Are you a sole proprietor, partner, or corporate officer in any business entity other than the business to which this application applies?  
 NO  YES list the name of all other businesses in which you have an ownership interest: \_\_\_\_\_  
 \_\_\_\_\_

**THIS EXEMPTION APPLICATION APPLIES ONLY TO THE PERSON SIGNING THE APPLICATION  
AND ONLY FOR THE BUSINESS ENTITY LISTED IN THE FOLLOWING SECTION**

Business Name:		Trade Name; d/b/a; or a/k/a:	
Business Mailing Address:		City:	State:
County:	Phone No.:	Nature of Business:	FEIN:
Unemployment Compensation Tax No:	Date Business Established:	No. of Employees:	

Do you have a certified or registered license issued to you pursuant to Chapter 489, Florida Statutes?  NO  
 YES - identify the license and list the license no. of all licenses issued to you: \_\_\_\_\_

**AFFIDAVIT OF APPLICANT:** I hereby certify that the information contained herein is true and correct to the best of my knowledge and belief; that this election does not exceed exemption limits for corporate officers or partners as provided in §440.02 Florida Statutes; and that I will secure the payment of workers' compensation benefits, pursuant to Chapter 440, Florida Statutes, for any employee I now have or may hereinafter acquire, for which my business is required by Florida law to secure such benefits.

TYPE/PRINT NAME OF PERSON APPLYING FOR EXEMPTION	SOCIAL SECURITY NO.	mo.    day    yr. DATE OF BIRTH
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APPLICANT'S SIGNATURE	DATE SIGNED
NOTARY STATE OF FLORIDA, COUNTY OF _____	

Sworn to and subscribed before me this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_, by \_\_\_\_\_

Personally Known \_\_\_\_\_ OR Produced Identification \_\_\_\_\_ Type of Identification Produced \_\_\_\_\_

NOTARY SIGNATURE \_\_\_\_\_ My Commission Expires \_\_\_\_\_