AF Group AccidentFund UnitedHeartland CompWest ThirdCoast Underwriters

Determination of Worker Status

Purpose: Policyholders submit this form to request the determination of the status of a worker for the purpose of completing his or her worker's compensation audit. This form will only be used to determine whether or not remuneration paid to a worker will be included on the policyholder's audit. All factors will be considered, however, no one factor is determinative of the worker's status.

Answer all questions as completely as possible. **Attach additional sheets if you need more space.** Provide information for the worker and policy period stated below. Determinations are based on the entire relationship between the policyholder and worker. **In order to make a determination as to whether an Employer/Employee status exists, please complete this analysis and provide as much of the following documentation as possible. This information must be provided and updated on an annual basis.**

Policyholder **Policy Period** **Policy Number**

Worker's Name: _____ Worker's DBA (applicable): _____

Worker's Place of Business Address (Include street address, city, state, and zip code) Worker's FEIN number

Worker is a: ☐ Sole Proprietor ☐ Partnership ☐ Corporation ☐ Limited Liability Company

How is the worker paid? ☐ per agreed upon price ☐ per hour ☐ salary ☐ commission ☐ piece work ☐ lump sum

Does the worker hire any employees, casual laborers, or subcontractors? ☐Yes ☐No If yes who pays them? _____

If the work is done under a written agreement between the policyholder and the worker, **attach a copy** (preferably signed by both parties).

Describe the term and conditions of the work arrangement. _____

The worker was contracted to perform: _____

What specific training or instruction is the worker given by the policyholder? _____

What expenses are incurred by the worker in the performance of services for the policyholder? _____

List the supplies, equipment, materials and property provided by the worker. Please provide a copy of an invoice from the contractor:

During the above policy period, the approximate percentage of payments to the subcontractor in relation to their total income for the year. ____%

Can the relationship be terminated by either party without incurring liability or penalty? If "No" explain your answer ☐Yes ☐No

Does the worker perform similar service for others? ☐Yes ☐No. If "Yes" is the worker required to get approval from the policy holder? ☐Yes ☐No

Below is a list of other individuals and business entities that the worker has performed services for over the past year.

Does the worker carry insurance? (e.g. workers compensation, general liability, professional liability, etc.) ☐Yes ☐No If "Yes" **please attach copies**

What type of advertising, if any, does the worker have (e.g. business listing in a directory or trade journal, newspaper advertisement, business card, etc.)? **Provide copies**, if applicable. Does the worker advertise their business on T.V. or radio? ☐Yes ☐No

Signature

I declare that I have examined this request, including accompanying documents, and to the best of my knowledge and belief, the facts presented are true, correct and complete. This form must be signed by the policyholder (i.e., Owner, Partner, Corporate Officer, Member/Manager) who has personal knowledge of the facts.

Signature _____ Title _____ Date _____