CAMComp
WORKERS' COMPENSATION PLAN

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Independent Contractor Statement

The following information must be provided on an annual basis so that CAMComp may make a determination as to whether an independent contractor status exists for a given policy period.

TO BE COMPLETED BY THE INDEPENDENT CONTRACTOR

Policyholder Name form is being filled out for: _____

Sub-Contractor Name: _____

Doing business as (DBA): _____
(If DBA is filed, attach a copy)

Address: _____

I operate as a □ Sole Proprietor □ Partnership □ Corporation □ Limited Liability Company
(If indicating Partnership, Corp., LLC.; a Certificate of Workers' Compensation Insurance or a properly filed Form BWC-337 must be submitted.)

1. The type of work I perform can be described as: _____
2. Period worked for above policyholder: _____to_____
3. My Federal ID Number is: _____
4. I hire employees or casual laborers to complete work for the named policyholder ☐ Yes ☐ No

   If yes, _____ Number or employees hired (attach Certificate of Workers' Compensation Insurance)
   If No, Form 1040 Schedule C (Profit or Loss from Business) may be provided as verification.
5. I hire sub-contractors to complete work for the named policyholder □ Yes □ No
   (If yes, additional information may be required)
6. I have General Liability coverage □ Yes □ No (**If yes**, a Certificate of GL Insurance is required.)

To further validate my standing as an independent contractor, I state **that my business has not worked exclusively** for the above-named insured and have worked for the following general contractors or clients during the past 12 months.

Required Information

NAME	CITY	PHONE
_____	_____	_____
_____	_____	_____
_____	_____	_____

I acknowledge that as a sole proprietor, I am by law not covered by or subject to the Workers' Disability Compensation Act.
I certify the above represents a true and complete statement of my status as an Independent Contractor. I understand a company representative may verify this statement at any time. If requested, I agree to provide documentation to verify my status as a sole proprietor.

Signed: _____ Date: _____
(Independent Contractor)

Phone Number: _____ Email Address: _____
(Required)

This form is utilized as a test of the above individual's independent status. By completing this form, it does not automatically remove the above individual's exposure from the audit of the policy period in question. **Additional information may be required.** If independent status is proven, the exposure will not be charged.