



State of Connecticut  
Workers' Compensation Commission

Please TYPE or PRINT IN INK

Rev. 10-2-2025

75

Date filed with WCC

# Coverage Election by Sole Proprietor

SEND THIS FORM TO THE OFFICE OF THE CHAIRPERSON

Pursuant to Public Act 22-89

By Mail: WORKERS' COMPENSATION COMMISSION  
21 OAK STREET, 4th FLOOR HARTFORD,  
CT 06106

Online: [https://wccct.govqa.us/WEBAPP/\\_rs](https://wccct.govqa.us/WEBAPP/_rs)

*If submitting by mail,  
include a self-addressed,  
stamped envelope to  
receive a date-stamped  
copy.*

(for WCC use only)

Incomplete and/or illegible forms will be returned unstamped.

**COVERAGE ELECTION - The Sole Proprietor is NOT covered by the Workers' Compensation Act, unless coverage is elected through the use of this form.**

To the Workers' Compensation Commission, 21 Oak Street, 4th Floor, Hartford, Connecticut 06106.

the undersigned sole proprietor of a business hereby elects to:

**BE INCLUDED FOR COVERAGE** under the Workers' Compensation Act pursuant to Section 31-275 of the Connecticut General Statutes

**REVOKE ANY PREVIOUS ELECTION OF INCLUSION** pursuant to the provisions of Section 31-275 of the Connecticut General Statutes

**AFFIRMATION** - Section 31-284 of the Connecticut General Statutes requires that workers' compensation insurance be obtained for all covered employees.

Dated on this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_.  
(number) (month) (year)

Employee Signature  PRINT Employee Name

Address \_\_\_\_\_ Date of Birth (required) \_\_\_\_\_

City/Town \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Business / Company Name  Address

City/Town \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**Federal Employer Identification Number** **CT Registration Number**

**Please be advised that the Workers' Compensation Commission accepts the coverage election form 75 for filing purposes ONLY.**

**The filer of this form is solely responsible for the accuracy of the information contained herein.**