



State of Connecticut
Workers' Compensation Commission

Please TYPE or PRINT IN INK

Rev. 12-15-2022

6B-1

Date filed with WCC

Coverage Election by Employees who are Members of a Partnership

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

By Email: WCC.Forms@ct.gov

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

and to (name of partnership) of (street address)

located in (city or town), (state), (zip code) and having a total of (number) partners:

We, (name of partner 1), (name of partner 2),

(name of partner 3), (name of partner 4), employees at

(exact name of partnership), (CT registration number)

hereby elect to:

BE EXCLUDED FROM COVERAGE under the Workers' Compensation Act pursuant to Section 31-275(10) of the Connecticut General Statutes

REVOKE ANY PREVIOUS ELECTION OF EXCLUSION from the provisions of Section 31-275(10) 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 (number) day of (month), 20 (year)

Partner 1: Signature Date of Birth (required)

Partner 2: Signature Date of Birth (required)

Partner 3: Signature Date of Birth (required)

Partner 4: Signature Date of Birth (required)

Please be advised that the Workers' Compensation Commission accepts the coverage election form 6B-1 for filing purposes ONLY.

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