INSTRUCTIONS FOR A NEW REGISTRATION

APPLICATION FOR EMPLOYER FEE PAID EMPLOYMENT AGENCY REGISTRATION

Application must be accompanied by:

- **A check or money order for the required registration fee of $150.00 payable to the Connecticut Department of Labor.**
- **A certificate of assumed or trade name as filed in Town Clerk's office if applicant is sole-proprietor or partnership**
- **If a corporation/limited liability company/limited liability partnership, your status as a Connecticut corporation/limited liability company/limited liability partnership, or authority to do business in Connecticut must be on file with the Connecticut Secretary of States' office. A computer search will be conducted by this office to make sure your business is registered with the Connecticut Secretary of States' office. If records do not indicate that you are active and in good standing, we will be in touch with your agency for additional paperwork**
- **Proof of Workers' Compensation insurance with complete Workers' Compensation Information form (PROOF OF WORKERS' COMPENSATION IS A CERTIFICATE OF INSURANCE) Corporations or Limited Liability Companies with no employees can be exempted from carrying Workers' Compensation Insurance for their officers or members by completing a Workers' Compensation Form 6b. Partnerships or Limited Liability Partnerships with no employees can be exempted from carrying Workers' Compensation Insurance by having the partners complete a Workers Compensation Form 6b1. Please contact this office if you need information on the Form 6b or 6b1. The original forms should be submitted to your local Workers' Compensation District office and copies sent to our office with your registration forms and fee.**

The following should be complied with:

- **Contact the Department of Revenue Services at (860) 297-4885 for sales tax regulations required on agency fees.**
- **Contact Wage & Workplace Standards Division at (860) 263-6790 for wage and hour regulations.**
- **Additional information:**

  ***Enclosed is information regarding employer/employee responsibilities under the Connecticut Unemployment Compensation Law.**

Questions concerning this application or paperwork to be submitted may be addressed to:

Thomas Wydra , Director
Connecticut Labor Department
Wage & Workplace Standards Division
200 Folly Brook Boulevard
Wethersfield, CT 06109-1114
Telephone: (860) 263-6791

STATE OF CONNECTICUT
DEPARTMENT OF LABOR
WAGE & WORKPLACE STANDARDS DIVISION
200 FOLLY BROOK BOULEVARD
WETHERSFIELD, CT 06109-1114

APPLICATION FOR EMPLOYER FEE PAID EMPLOYMENT AGENCY REGISTRATION

New Registration ☐ **Renewal** ☐

I(We) _____ **hereby apply for a registration**

Doing Business as: _____

Business address: _____
(Street Address - Registration cannot be issued to a Post Office Box)

_____ _____ _____ **(** **)** _____ **-** _____
(City) **(State)** **(Zip)** **(Business Telephone Number)**

Please list additional locations on second page

Owner is:

☐ **Sole-Proprietorship** ☐ **Partnership** ☐ **Corporation**

If business is: • Sole Proprietorship - list owner • Partnership - list all partners • Corporation - list all officers and directors.
• Limited Liability Corporation - list all members.

Name	**Home Address**	**Title**

Please provide your social security # (SSN) _____ **or your federal employer identification number**

(FEIN) _____**.**

I (We) certify that the information provided on this application for Employer Fee Paid Employment Agency Registration is true and accurate.

_____ _____
Signature(s) of Officers, Members, Partners or Proprietor **Date**

_____

****

(For Department of Labor Use Only)

Approved By: _____ Date _____

Issuance Date: _____

Effective Date: _____

Additional locations:

IMPORTANT

WORKER'S COMPENSATION INSURANCE

You MUST return this form with the requested information

Section 31-286a of the Connecticut General Statutes requires that any applicant for a license or permit and/or renewal of the license or permit who has employees in the State of Connecticut, must first provide a CURRENT certificate of Worker's Compensation Insurance in order for us to ISSUE or RENEW YOUR LICENSE or REGISTRATION.

Print, business name

Please check one (1) box:

( ) I do not have any employees

Print business address

( ) I have (an) employee(s) and have enclosed Worker's Comp. Insurance Certificate.

Print your name

Signature

Date

ACORD. CERTIFICATE OF INSURANCE

ISSUE DATE (MMIDDIYY)

PRODUCER

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW.

COMPANIES AFFORDING COVERAGE

INSURED

COMPANY LETTER A

COMPANY LETTER B

COMPANY LETTER C

COMPANY LETTER D

COMPANY LETTER E

COVERAGES

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED, NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

LTR	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MMIDDIYY)	POLICY EXPIRATION DATE (MM/DD/YY)	LIMITS
	GENERAL LIABILITY				GENERAL AGGREGATE $
	COMMERCIAL GENERAL LIABILITY				PRODUCTS-COMP/OP AGG. $
	CLAIMS MADE X OCCUR.				PERSONAL & ADV. INJURY $
	OWNER'S & CONTRACTOR'S PROT.				EACH OCCURRENCE $
					FIRE DAMAGE (Any one fire) $
					MED. EXPENSE (Any one person) $
	AUTOMOBILE LIABILITY				COMBINED SINGLE LIMIT $
	ANY AUTO				BODILY INJURY (Per person) $
	ALL OWNED AUTOS				
	SCHEDULED AUTOS				
	HIRED AUTOS				BODILY INJURY (Per accident) $
	NON-OWNED AUTOS				
	GARAGE LIABILITY				PROPERTY DAMAGE $
	EXCESS LIABILITY				EACH OCCURRENCE $
	UMBRELLA FORM				AGGREGATE $
	OTHER THAN UMBRELLA FORM				
	WORKER'S COMPENSATION				STATUTORY LIMITS
	AND				EACH ACCIDENT $
	EMPLOYERS' LIABILITY				DISEASE-POLICY LIMIT $
					DISEASE—EACH EMPLOYEE $
	OTHER				

SAMPLE FORM

DESCRIPTION OF OPERATIONS/LOCATIONS/VEHICLES/SPECIAL ITEMS

CERTIFICATE HOLDER

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING COMPANY WILL ENDEAVOR TO MAIL ____ DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, BUT FAILURE TO MAIL SUCH NOTICE SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE COMPANY, ITS AGENTS OR REPRESENTATIVES.

AUTHORIZED REPRESENTATIVE

State of Connecticut
Workers' Compensation Commission

Please TYPE or PRINT IN INK

Rev. 1-15-2004

6B

Date filed in District

(for WCC use only)

Coverage Election by Employee who is an Officer of a Corporation, Manager of an LLC, or Member of a Multiple-Member LLC

Pursuant to Section 31-321 C.G.S., this notice must be served upon the Compensation Commissioner in person or by registered or certified mail.

Coverage Election

To the Compensation Commissioner for the _____ (district number) Compensation District of Connecticut at _____ (city of compensation office)

and to _____ (name of employer) of _____ (employer's city/town), Employer:

I, _____ (name of employee), _____ (soc. sec. # — optional), an Employee of

_____ (exact name of corporation or LLC), located at

_____ (complete address of corporation or LLC), and also the

_____ (office held) of said Corporation or LLC,

hereby elect to:

- ☐ **BE EXCLUDED FROM COVERAGE** under the Workers' Compensation Act pursuant to Section 31-275 of the Connecticut General Statutes
- ☐ **REVOKE ANY PREVIOUS ELECTION OF EXCLUSION** from 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 _____ (number) day of _____ (month), 20 _____ (year).

Employee Signature _____ Soc. Sec. # *(optional)* _____

Employee Address _____

City/Town _____ State _____ Zip Code _____

State of Connecticut
Workers' Compensation Commission

Please TYPE or PRINT IN INK

Rev. 1-15-2004

6B-1

Date filed in District

(for WCC use only)

Coverage Election by Employees who are Members of a Partnership

Pursuant to Section 31-321 C.G.S., this notice must be served upon the Compensation Commissioner in person or by registered or certified mail.

If there are more than four partners, attach additional sheets for names, signatures, and social security numbers.

Coverage Election

To the Compensation Commissioner for the _____ (district number) Compensation District of Connecticut at _____ (city of compensation office)

and to _____ (name of partnership)

of _____ (complete address of partnership) 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

Affirmations

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 _____ Soc. Sec. # *(optional)* _____

Partner 2: Signature _____ Soc. Sec. # *(optional)* _____

Partner 3: Signature _____ Soc. Sec. # *(optional)* _____

Partner 4: Signature _____ Soc. Sec. # *(optional)* _____