WCE-1
APPLICATION FOR WORKER'S COMPENSATION CLEARANCE CERTIFICATE

State Form 45899 (R7 / 3-15)
Approved by State Board of Accounts, 2015
WORKER'S COMPENSATION BOARD OF INDIANA

* This agency is requesting disclosure of your Social Security Number in accordance with IC 4-1-8-1; disclosure is voluntary and you will not be penalized for refusal.

NOTE: A contractor who knowingly or intentionally causes or assists employees, including temporary employees, to file a false statement and supporting documentation of independent contractor status commits a Level 6 felony. IC 6-3-7-5(m)

INSTRUCTIONS:
1. *Please type or print.*
2. ***Payment must be made using a money order or certified check.***
3. *Mail this completed application and payment to the* ***Indiana Department of Revenue, PO Box 2305, Indianapolis, IN 46206-2305.***

Name of independent contractor *(last, first)*	Name of business	Specified trade
Address *(number and street, city, state, and ZIP code)*		Telephone number ( )
E-mail address	Social Security Number*	Affidavit of exemption number *(STATE USE ONLY)*
Are you an Indiana resident? ☐ Yes ☐ No	If no, please enter your state of residence	

Under the provisions of IC 22-3-2-14.5 and/or IC 22-3-7-34.5, I, the undersigned, am hereby requesting issuance to me of an Independent Contractor Affidavit of Exemption:

☐ I am an independent contractor as defined by IC 22-3-6-1 (b) (7) and / or IC 22-3-7-9 (b) (5).

☐ I am the sole proprietor as defined by IC 22-3-6-1 (b) (4) and IC 22-3-7-9 (b) (2) and am thereby exempted from worker's compensation coverage.

Name of sole proprietorship	Social Security Number*

☐ I am a partner in a partnership as defined by IC 22-3-6-1 (b) (5) and IC 22-3-7-9 (b) (3) and am thereby exempted from worker's compensation coverage.

Name of partnership	Federal Identification Number

☐ I am a member or manager of a limited liability company as defined by IC 22-3-6-1(b)(9) and am thereby exempted from worker's compensation coverage.

Name of LLC	Federal Identification Number

I ☐ do ☐ do not have other employees.	I ☐ do ☐ do not have Worker's Compensation insurance through a private insurance carrier.
Signature of applicant	Date signed *(month, day, year)*

This affidavit certifies that the above named person is an independent contractor as defined by the indicated provisions of law, that the above named person has worker's compensation or is a qualified self-insurer as to any and all employees in their hire, and that the above named person desires to be exempt from worker's compensation coverage and foregoes the right of recovery under the Worker's Compensation Act from anyone for whom this person works as an independent contractor. This affidavit is binding and holds harmless any person and their worker's compensation insurance carrier contracting with the above named person (as an independent contractor) and their worker's compensation insurance carrier. This affidavit is not valid without the stamp of the Worker's Compensation Board. This affidavit is valid for one year from the date of issue. **You must re-apply each year to maintain exempt status. This information may be shared with the Internal Revenue Service and/or other states.**

FOR STATE USE ONLY	
A $20.00 non-refundable filing fee is required. ☐ $5.00 Department of Revenue filing fee paid ☐ $15.00 Worker's Compensation Board filing fee paid	Date issued *(month, day, year)*