WISCONSIN SUPPLEMENTARY ELECTION OF COVERAGE FORM

I, we, the individuals, or members of a Limited Liability Partnership/Company, named below, do hereby elect to be covered as employees under the policy applied for pursuant to Section 102.075, Wis. Stats. I, we, understand that the coverage will be provided by endorsement attached to the policy, and that this coverage will remain in effect for the entire policy term unless terminated.

Any sole proprietor, partner or member who elected coverage under this section may withdraw that election upon 30 days' prior written notice to the insurance carrier and the Wisconsin Compensation Rating Bureau. I, we, also understand that this coverage will also be continued on all renewal policies, unless change is requested at the time of renewal.

Finally, I, we, understand that there is a premium charge for this coverage based on an "assigned payroll" which may exceed my/our actual income.

Business Name
(DBA, if any): _____

Business Address: _____

_____

_____

Individuals or Partners Electing Coverage:

Name (Please Print): _____

Title: _____

Signature: _____ Date: _____

Name (Please Print): _____

Title: _____

Signature: _____ Date: _____

Name (Please Print): _____

Title: _____

Signature: _____ Date: _____