FORM 6B Rev. 6/93

WORKERS' COMPENSATION COMMISSION OF CONNECTICUT
COVERAGE SELECTION FORM BY EMPLOYEE WHO IS AN OFFICER OF THE CORPORATION

(Ink or typewriter to be used)

To the Compensation Commissioner for the ______ Compensation District of Connecticut
(Dist #)

at ________________________, and to ____________________________ of
(City of Compensation Office) (Name of Employer)

________________________, EMPLOYER:
(Employer's Town)

I ________________________, an employee at ____________________________
(Name of Employee) (Exact Name of Corporation)

located at ____, who am also the
(Complete address of the corporation)

________________________, of said corporation, hereby elect to:
(Office held)

[ ] be Excluded from coverage under the Workers' Compensation law under provisions of Section 31-275 of the Connecticut General Statutes.

[ ] Revoke any previous election of exclusion from the provisons of Section 31-275 of the Connecticut General Statutes.

Note: This notice will not be effective until served upon the Commissioner and the Employer by personal delivery, or registered/certified mail.

AFFIRMATION

Dated on this _____ day of ____________ 19 _____.

Signature of Employee ____

Employee Social Security # ____

Employee Street Address ____

City, State, Zip ____