Accident Fund℠
232 S. Capitol Avenue
P.O. Box 40790
Lansing MI 48901-7990

Determination of Worker Status

Purpose: Policyholders submit this form to request the determination of the status of a worker for the purpose of completing his or her workers compensation audit. This form will only be used to determine whether or not remuneration paid to a worker will be included on the policyholder's audit. This form is only valid for the worker and policy period listed below. This determination is for the audit period in question **and does not affect the payment of claims**.

Completing the form: Answer all questions as completely as possible. **Attach additional sheets if you need more space**. Provide information for the worker and policy period stated below. Determinations are based on the entire relationship between the policyholder and worker.

Accident Fund Policyholder	Policy Period	Policy Number

In order to make a determination as to whether an Employer/Employee status exists, please complete this analysis and provide as much of the following documentation as possible. This information must be provided on an annual basis.

Worker's Name			Worker's DBA (applicable)	
Worker's Address (Include street address, city, state and Zip code.)			Worker's Tax ID	
Worker is a:	☐ Sole Proprietorship Did the sole proprietor use any employees, casual labor, or uninsured subcontractors to complete the work? ☐Yes ☐ No	☐ Partnership	☐ Corporation	☐ Limited Liability Company

A. How did the worker obtain the job? ☐ Application ☐ Bid ☐ Employment Agency ☐ Other (specify)
Type of pay the worker receives: ☐ Salary ☐ Commission ☐ Hourly Wage ☐ Piece Work ☐ Lump sum ☐ Other (specify)

B. If the work is done under a written agreement between the policyholder and the worker, **attach a copy** (preferably signed by both parties). Describe the terms and conditions of the work arrangement.

C. What specific training or instruction is the worker given by the policyholder?

D. How does the worker receive work assignments? And who determines how and when the assignments are performed?

E. Is the worker required to provide the services personally?

F. If substitutes or helpers are needed, who hires them? Who pays them?

G. List the supplies, equipment, materials and property provided by each party:

The policyholder: _____

The worker: _____

Other party: _____

H. What expenses are incurred by the worker in the performance of services for the policyholder?

I. Does the worker carry insurance (e.g., workers compensation, general liability, etc.)? If "Yes", **please attach copies**.

J. List the benefits available to the worker (e.g., paid vacations, sick pay, pensions, bonuses).

K. Can the relationship be terminated by either party without incurring liability or penalty? If "No," explain your answer.

L. Does the worker perform similar services for others? If "Yes," is the worker required to get approval from the policyholder?

M. What type of advertising, if any, does the worker do (e.g., business listing in a directory, business cards, etc.)? **Provide copies**, if applicable.

Signature

I declare that I have examined this request, including accompanying documents, and to the best of my knowledge and belief, the facts presented are true, correct and complete. This form must be signed by the policyholder (i.e., Owner, Partner, Corporate Officer, Member/Manager) who has personal knowledge of the facts.

Signature _____ Title _____ Date _____