NOTICE FOR WORKER'S COMPENSATION AND OCCUPATIONAL DISEASES COVERAGE (79)

State Form 36097 (R2 / 1-88)

Indiana Worker's Compensation Board
601 State Office Building
100 North Senate Avenue
Indianapolis, IN 46204

Pursuant to Section 73 (IC 22-3-6-1) and Section 2 (IC 22-3-7-1), the Indiana Worker's Compensation Board is hereby notified that the undersigned applicant does hereby elect to be covered for worker's compensation and occupational diseases under the law.

This notice of election will not be valid unless it is attached to Form 18-A furnished by the insurance company that is writing the policy covering the risk.

Applicant's Name *(Typed or Printed)*		Federal I.D. Number
Home Street Address	City, State, ZIP Code	
I certify that I am a ☐ Sole Proprietor or ☐ Partner	Name of Business	Nature of Business
Business Street Address	City, State, ZIP Code	

Insurance Carrier	Address	Telephone Number ( )
I certify that I am actually and actively engaged in said business.	☐ I, the undersigned, do elect to be covered by Worker's Compensation and Occupational Diseases coverage until I file a request for cancellation of this election.	
Date Signed	Applicant's Signature	