MICHIGAN WORKERS' COMPENSATION ELECTION FORM

Employer Legal Name:	
Date of Birth:	
Social Security Number/EIN/Tax ID:	
Phone Number:	( )
Street Address Where Services are Provided: (No P.O. Boxes)	
City, State, Zip:	
Estimated Annual Number of Hours Worked (all employees):	
Effective Date of Coverage: (cannot backdate coverage)	