

**NORTH COUNTRY COMMUNITY MENTAL HEALTH  
NOTICE TO PROVIDER SUBCONTRACTORS**

**In Lieu of Workers' Compensation Insurance for Subcontractors who are Qualified**

Our agency must keep on file a copy of certificates of liability insurance showing worker's compensation coverage for all subcontractors. Alternatively, if either of the statements below are true and correct, this completed form will be acceptable to North Country CMH in lieu of a certificate of insurance, **pending verification of exclusion from the Michigan Department of Labor Workers' Compensation Agency**. However, all information must be completed and received for validity.

Completion of this form **does not fulfill your obligation** under Michigan law to provide workers' compensation insurance. Form WC-337, Notice of Exclusion, provided by the Michigan Department of Labor Workers' Compensation Agency, is used to exclude certain individuals from insurance coverage as permitted by statute. To find out whether you qualify for this exclusion and obtain a copy of the form, contact the Compliance & Employer Records Division at (517) 322-1195. Upon authorization by the Workers' Compensation Agency please provide North Country CMH with an approved copy of the Notice of Exclusion.

1. I, \_\_\_\_\_ am a sole proprietor who has no more than two (2) part-time employees (up to 35 hours/week/each) and my remaining employees are my spouse, child or parent.

If you operate under an assumed name, please attach a copy of the assumed name certificate (DBA) you have filed with the county or state.

\_\_\_\_\_  
Name of North Country CMH Sole Proprietor

\_\_\_\_\_  
Social Security #

**—OR—**

2. I operate as a corporation, a partnership or a licensed liability corporation (LLC) which has no employees other than its stockholding officers, partners or member managers, respectively.

\_\_\_\_\_  
Name of Corporation, Partnership or LLC

\_\_\_\_\_  
Employer ID#

I hereby certify that the above is true and correct to the best of my knowledge and belief:

\_\_\_\_\_  
Signature  
Title \_\_\_\_\_

\_\_\_\_\_  
Date

**Please return completed form to:**  
Contract Manager  
North Country Community Mental Health  
1420 Plaza Drive  
Petoskey, MI 49770