MAINE WORKERS' COMPENSATION ELECTION FORM

Employer Legal Name:	
Participant Name, If Different From Employer:	
Social Security Number/EIN/Tax ID:	
Phone Number:	( )
Street Address Where Services are Provided: (No P.O. Boxes)	
City, State, Zip:	
Estimated Annual Payroll:	$
(cannot backdate coverage) Effective Date of Coverage:	