DIVISION OF WORKERS' COMPENSATION

MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS

EMPLOYER'S AFFIDAVIT OF EXCEPTION FROM WORKERS' COMPENSATION BENEFITS

This form must be filed with Form 1 - Employee's Application for Religious Exception, Form 3 - Benefits and the Employer's Affidavit of Exception from Workers' Compensation Benefits, and Form 4029 - Pre-Approved Federal Form 4029 – Exemption from Social Security and Medicare Taxes and Waiver of Benefits.

Name of Business Owner (*Last, First, MI*)	Employer Business Name		Federal Employer Identification No.
Mailing Address			Phone Number
City	County	State	ZIP Code (*9-Digit*)
Employer Email Address			
Employer is: ☐ Sole Proprietor ☐ General Partnership ☐ Limited Liability Partnership ☐ Limited Liability Company ☐ Corporation			
Total Number of Persons you Employ at the Time of this Application:	Total Number of Employees for Which There is an Existing Approved Employee Exception:		
On a separate page, provide a legible list of your current employees (including seasonal, temporary, and part-time) and clearly mark which employees already have approved exceptions. The list of employees should match the information provided above. Rescissions will be granted for individuals who received a religious exception for employment with your business but are no longer employed by you.			
Does the Employer Currently Have Workers' Compensation Insurance: ☐ Yes ☐ No	If Insured, What is the Name of the Insurance Company:		

My name is _____. I am of sound mind, capable of making this affidavit, and personally acquainted with the facts herein stated.

I affirm that I am the employer of _____.

(Employee's birth name as shown on the application)

Check one: I am ☐ I am not ☐ a construction employer.

I do hereby state that I am a member of the _____.

(Name of recognized religious sect and district/congregation)

Its established tenets and/or teachings conscientiously oppose member acceptance of any private or public insurance benefits which makes payments in the event of death, disability, old age, retirement or towards the cost of medical bills and provision of services for medical bills (including the benefits of any insurance system established by the Federal Social Security Act, 42 U.S.C. 301 to 42 U.S.C. 1397jj), and I adhere to said tenets and/or teachings.

I have reviewed this affidavit and to the best of my knowledge and belief, it is true and correct. I understand that providing false and fraudulent information on this affidavit and waiver would be subject to investigation by the Division's Fraud & Noncompliance Unit and possible prosecution pursuant to §287.128 RSMo or other applicable laws.

STATE OF MISSOURI)
)
COUNTY OF _____)

_____

Printed Name and Signature of Employer and Date

Subscribed and affirmed to before me this

_____ day of _____, 20____.

My Commission Expires:

_____

Notary Public

(Notarial Seal)

Missouri Division of Workers' Compensation is an equal opportunity employer/program. Auxiliary aids and services are available upon request to individuals with disabilities. TDD/TTY: 800-735-2966 Relay Missouri: 711