



**Election to Exclude Certain Relatives of  
 Managers of a Limited Liability Company**  
 Minnesota Statutes § 176.041, subd. 1(20)

Use this form to exclude (omit) from workers' compensation coverage certain employees who are related within the third degree of kindred to a manager of a limited liability company (LLC) who owns at least 25 percent membership in the LLC. A manager of the LLC must complete and sign this form. A chart showing relatives within the third degree of kindred is online at [www.dli.mn.gov/WC/Pdf/infosheet\\_3rd\\_degree\\_kindred.pdf](http://www.dli.mn.gov/WC/Pdf/infosheet_3rd_degree_kindred.pdf).

**You do not need to file this form if** you only intend to exclude the spouse, parent or children of a manager who owns at least a 25 percent membership in the LLC – they are automatically excluded from coverage.

**Section 1. Information about the limited liability company**

Legal name of the LLC exactly as registered with the Minnesota Secretary of State		Phone number	
Mailing address	City	State	ZIP code

**Section 2. Eligibility**

A. Is this LLC owned by 10 or fewer members?	<input type="checkbox"/> Yes <input type="checkbox"/> No
B. Did this LLC have less than 22,880 hours of payroll in the preceding calendar year?	<input type="checkbox"/> Yes <input type="checkbox"/> No
C. Is this LLC currently registered as active with the Minnesota Secretary of State?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If you answered "no" to any of the questions above, you are not eligible to exclude relatives other than the spouse, parent or children of the manager from workers' compensation coverage. Contact your insurance agent to make sure they are covered.	

**If you answered "yes" to all of the questions in Section 2, complete Sections 3 through 5.**

**Section 3. Membership interest owned by the manager(s) of the LLC**

List the names of all managers who own at least 25 percent membership interest in the LLC	Percent of the LLC membership interest owned by this manager

(over)

#### Section 4. Relatives to be excluded from workers' compensation coverage

List the relatives to be excluded from workers' compensation coverage and their relationship to one of the managers listed in Section 3. (Attach an additional sheet if necessary.)

Name of the relative to be excluded	Name of the related LLC manager	Relationship to the manager

#### Section 5. Certification

**By signing this form I certify** that all information provided is complete and accurate to the best of my knowledge and that I have the authority to sign this form for the LLC named in Section 1.

Manager's name (print or type)	Phone number
Signature	Date signed
Have the relatives listed in Section 4 been notified that this form to exclude them from workers' compensation coverage is being filed?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Submit a copy of this form to your workers' compensation insurance company, if any. If you change insurance companies, submit a copy of this form to the new insurance company.

Refile this form with the Department of Labor and Industry (DLI) and your workers' compensation insurer if any information in Sections 2, 3 or 4 changes and you still want to exclude relatives from workers' compensation coverage.

#### File a copy of this form with the Department of Labor and Industry.

##### In person

Department of Labor and Industry  
Special Compensation Fund  
443 Lafayette Road N.  
St. Paul, MN 55155

##### By mail

Department of Labor and Industry  
Special Compensation Fund  
P.O. Box 64229  
St. Paul, MN 55164-0229

##### By fax

(651) 215-9099

#### Notice

- The election to exclude relatives from workers' compensation coverage is not effective unless this form has been filed with DLI. If the information provided on this form is accurate and meets the statutory requirements, the effective date of this exclusion will be based on the date DLI receives this form.
- DLI does not guarantee that this election to exclude the relatives listed in Section 4 from workers' compensation coverage is legally effective. The manager signing this form is responsible for determining the LLC's legal obligations and for correctly and accurately completing this form. DLI will notify you of potential defects if they are apparent, but you are encouraged to consult an attorney about the legal effect of this election. If the information provided is not accurate and complete, or the information changes, the LLC or manager(s) may be liable for workers' compensation injuries of the relatives listed in Section 4.
- The information you provide on this form may be available to the public upon request.

This document can be given to you in Braille, large print or audio by calling (651) 284-5019 or 1-800-342-5354.

**Questions? Contact Dave Horning at (651) 284-5422 or [dave.horning@state.mn.us](mailto:dave.horning@state.mn.us).**