WORKERS COMPENSATION CERTIFICATION

I hereby certify that effective the date of my Contract with the County of Crow Wing and at all times in the performance of such Contract that:

[ ] I have, and will maintain in full force and effect, a policy of Workers Compensation Insurance in compliance with the Laws of the State of Minnesota with the following insurance company:

_____

___

COMPANY NAME

_____

___

AGENT'S NAME, ADDRESS AND TELEPHONE NUMBER

_____

___

POLICY NUMBER (EFFECTIVE DATE)

OR

[ ] I will perform said Contract myself alone and do not have and will not have any employee or employees assisting me with the performance of the Contract and am not required by the Laws of the State of Minnesota to obtain and maintain a policy of Workers Compensation Insurance in the performance of this Contract.

I understand that this statement is made as a material part of the Contract which I have contemporaneously made with the County of Crow Wing.

_____

Date

_____

Signature of Contractor