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## SOLID WASTE HAULER ANNUAL CONTRACTOR LICENSE APPLICATION

Applicant Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Applicant Address: \_\_\_\_\_  
Street City State Zip Code

Business Name: \_\_\_\_\_

Business Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Business Address: \_\_\_\_\_  
Street City State Zip Code

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

### REQUIREMENTS:

1. Liability insurance (Attach Copy)
2. \$2,000 License bond (Attach Copy)
3. \$150.00 Fee
4. Worker's compensation insurance as required by law (Complete Attached Form)
5. Department of Revenue requirement (Complete Attached Form)

**LICENSE EXPIRES:** December 31<sup>st</sup> of each year

### Office Use Only

Date Paid: \_\_\_\_\_

Amount Paid: \$ \_\_\_\_\_

Date Council Approved: \_\_\_\_\_

License No: \_\_\_\_\_



**- CERTIFICATE OF COMPLIANCE -**

**MINNESOTA WORKERS' COMPENSATION LAW**

Minnesota Statute, Section 176.182 requires every state and local licensing agency to withhold the issuance or renewal of a license or permit to operate a business or engage in an activity in Minnesota until the applicant presents acceptable evidence of compliance with the Workers Compensation Insurance Coverage Requirement of MSS Chapter 176. Information required: the name of the insurance company, policy number, and dates of coverage or the permit to self-insure. This information will be collected by the licensing agency and retained in their files.

This information is required by law and licenses and permits to operate a business may not be issued or renewed if it is not provided and/or is falsely reported. Furthermore, if this information is not provided or falsely stated, it may result in a \$1,000 penalty assessed against the applicant by the Commissioner of the Department of Labor and Industry.

Insurance Company Name (Not Insurance Agent): \_\_\_\_\_

Policy Number: \_\_\_\_\_ Coverage Period: \_\_\_\_\_ to \_\_\_\_\_

**(or)**

I am not required to have workers' compensation liability coverage because:

- I have no employees.
- I am self-insured (include evidence of self-insurance).
- I have no employees who are covered under the worker's compensation law, (these include spouses, parents, children, and certain farm employees).

I certify that the information provided above is accurate and complete and that a valid worker' compensation policy will be kept in effect at all times as required by law.

**Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

(Last, First, Middle)

**Doing Business As:** \_\_\_\_\_

(Business Name if Different Than Your Name)

**Business Address:** \_\_\_\_\_

**Street**

**City**

**State**

**Zip Code**

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_