Commonwealth of Pennsylvania Department of Labor & Industry Bureau of Workers' Compensation COMPLIANCE SECTION 1171 S. Cameron Street, Room 103 Harrisburg PA 17104-2501 (717)787-3567

## **EXECUTIVE OFFICER'S DECLARATION**

I, the below named Executive Officer, do hereby knowingly and voluntarily elect not to be an employee of the below named corporation for

INSTRUCTIONS: Each executive officer having an ownership interest in a corporation seeking exemption must complete an original Declaration for submission with the Corporation's Application for Executive Officer Exception. The total ownership interest of all Declarations combined must equal 100%. See the Form Completion Hints on the reverse side for additional information and the Application for Executive Officer Exception for filing instructions.

		ses ylva					,													wa	ive	any	y ar	ia a	all D	en	ents	s an	a ri	gnts	s to	wn	iicn	ım	nıgr	nt de	e er	TUTIE	ea u	nae	rtne	3
l do	he	ereb	y s	tate	e ar	nd a	ffirr	n th	at I	an	n aı	n e	xec	utiv	e c	ffic	er	who	o:	(ch	eck	on	ly o	ne	bo	x)																
	]	Has	s aı	n ov	vne	ersh	ip i	nte	res	t in	а	Sul	och	apt	ter	Sc	corp	oor	atio	on a	as c	def	ine	d b	y th	ne l	Fed	lera	l Ta	ax F	Refo	orm	ı C	ode	e of	197	71.					
		Has	s a	t lea	ast	5%	OW	ne	rshi	ip iı	nte	res	t in	а	Sul	och	ap	ter	С	cor	por	atio	on a	as	def	ine	d b	y th	e F	ede	eral	Та	ıx F	Refo	orn	n Co	ode	of	197	1.		
		Ser	ve	s vo	olui	ntar	ily a	and	wi	tho	ut ı	rem	านท	era	itio	n fo	or a	a no	onp	rof	it c	orp	ora	tio	n																	
kne	owl sifi	ledo cati	ge, ion	inf to	orı au	mat the	ior riti	an es.	id k	oeli	ief.	Th	is '	ver	rific	cati	ion	is	m	ade	e sı	ıbj	ect							of 1	8 P	a.C ۸		. §	49	rrec 04, Day		atir				my vorn
	Sig	gna	itur	e o	tΕ	xec	utiv	ve (	Otti	cer																			_		Dat	e [			-[		_] .					
Cor	oor	ation	ı's I	-ull	Lec	al N	ame	e	Т	Г			П	$\neg$	$\neg$	$\neg$	$\neg$	$\neg$	$\neg$	$\neg$	$\neg$	Т	$\overline{}$	Т	_	$\top$		$\top$	Т	Г												
							$\perp$																																			
Title	of	Exe	cut	ive (	Offic	cer	_	_	_	_												_		_					_													
Firs	t Na	ame					_																											_								
0						T	Τ	Τ	Π	Π																																
														1											Ę	Ξ,	1	3			Λ	7	7 (	7	二 二	1						
Mid	dle	Nan	ne																						•		•	J			U		1	J,	J	)						
							Т	Т																																		
	. NIe																																									
Las	l INc	ame				Т	Τ	Τ	Τ	Π											Т		Т	T		T			Τ			Т	Т	Т								
													Ш											_																		
Suf	ix (	ex: c	Jr.)			Soc	ial S	Secu	ırity	Nu	mbe	er	Τ							Pei	rcen	tag	e of	Ov	vner	shi	p		T	elep	ohor	ne	Г	Τ								
۸۵۵	roo	o (P		2000	or	rooi	don	00.0	ddr	000	00/	2001	oble	~\		_									_															_		
Auc	162	s (B	usii	1625	S OI	1621	uen	Ce a	luui	655	acc	Сері	abit	<del>=</del> )																												
City																					Stat	e		-	Zip																	
Í																													]-													

## FORM COMPLETION HINTS

## In General:

This form will be machine-read by the Bureau of Workers Compensation. The red lines and boxes will "drop out" during processing so that the information typed or written (typed is preferable) on the form can be automatically "read" and used by the Bureau's computer system. Forms that do not meet Bureau requirements will be rejected. Do not staple forms together.

## Where to Type:

When typing a form, begin in the left most box of each set of red boxes. Use normal spacing (do not put one letter per box) staying within the range of boxes. Avoid typing in the margins. <u>Use black ink only</u>. For example:

First Name  JOHNATHAN	JONES
Where to Handwrite: When completing a form by hand, print clearly, using uppercase each box. For example:	se letters, in <u>black ink only</u> , placing one letter or numeral within
First Name  JOHNATHAN	Last Name    J O N E S
<b>Dates:</b> Enter all dates as MMDDYYYY. For example:	
Month Day Year  04272005 OR	Month Day Year 2 0 0 5
Telephone Numbers: The first three digits are the area code. No need for parenthes	sis. For example:
Telephone	Telephone

OR

Auxiliary aids and services are available upon request to individuals with disabilities. Equal Opportunity Employer/Program

| 5 | 5 | 5 | 3 | 8 | 9 | 4 |