

**CORPORATE OFFICERS, MEMBERS, MANAGERS, PARTNERS, SOLE PROPRIETOR OR OTHERS
WORKERS COMPENSATION ELECTION/REJECTION/REVOCATION FORM
Pursuant to State Insurance or Labor Code**

Depending on your respective State Insurance or Labor Code, an Officer, Partner, Member, Manager, Sole Proprietor or Other individual may be required or permitted to either **ELECT** or **REJECT** workers compensation coverage. This form provides documentation of your decision as your state has not promulgated a form for this purpose. The coverage selection indicated below shall apply to all subsequent renewal policies until an insurer representative is properly notified of a change in coverage.

Please fill in all sections that pertain to your company, sign and return to your insurer representative.

COMPANY NAME:			
MAILING ADDRESS:			
PHONE:			
CONTACT PERSON:			
TYPE OF COMPANY:	<input type="checkbox"/> Corporation	<input type="checkbox"/> Sole Proprietor	<input type="checkbox"/> Limited Liability Company
	<input type="checkbox"/> Partnership	<input type="checkbox"/> Other – Describe:	

SELECT ONE CHOICE ONLY:

- The person(s) named below is/are **ELECTING** coverage.
- The person(s) named below is/are **REJECTING** coverage. *(Signature Required)*
- The person(s) named below is/are withdrawing the previous election of coverage. *(Signature Required)*
- The person(s) named below is/are withdrawing the previous rejection of coverage.

TYPE OF INDIVIDUAL(S):	<input type="checkbox"/> Officer	<input type="checkbox"/> Sole Proprietor	<input type="checkbox"/> Member
	<input type="checkbox"/> Partner	<input type="checkbox"/> Manager	<input type="checkbox"/> Other:
NAME OF INDIVIDUAL:	TITLE:	SIGNATURE	
1.			
2.			
3.			
4.			
5.			

AUTHORIZED/SUBMITTED BY:

Full Name (Print)		Title	
Signature	Today's Date	Coverage Effective Date	

WUNN1G12