INSTRUCTIONS FOR EMPLOYEE'S WRITTEN NOTICE OF REJECTION

It is unlawful for an employer to require an employee to execute a rejection of the Workers' Compensation Act as a condition of obtaining or maintaining employment. An employer shall not terminate an employee for refusal to execute this form. Effect shall not be given to any form not voluntarily executed. An employer can be fined up to $2,000 for each notice it requires an employee to execute as a condition of employment. The fact that all employees of an employer have executed rejections is evidence tending to prove that execution of the rejection was not voluntary.

Pursuant to KRS 342.395, a Rejection Notice (FORM 4) does not become effective until the **original** of the Form 4 is received from the employer and accepted for filing by the Department of Workers' Claims. Photocopies or facsimiles of this form will not be accepted. All parts of the Form 4 must be completed as incomplete forms will not be accepted for filing. Executed Rejection Notices should be mailed to: **Department of Workers' Claims, ATTENTION: Enforcement Branch, Prevention Park, 657 Chamberlin Avenue, Frankfort, Kentucky 40601.**

If you want to have a filing of a Form 4 acknowledged by the Department, you must forward with the original, a photo static copy and a self-addressed stamped envelope.

An employer must keep on file copies of all Rejection notices signed by current employees and open those records to inspection upon request of representatives of the Department of Workers' Claims.

An employee may withdraw the rejection of coverage by executing a written notice of withdrawal form (Form 5), setting forth the time at which the withdrawal is to be effective. The employer must, in turn, notify the Department of Workers' Claims of this election to withdraw the rejection. Withdrawals are not effective as to any injury sustained or disease incurred less than one week after the notice is filed.

Contact the Enforcement Branch at (800)731-5241, if you have any questions.

If you need to order blank forms, please contact Administrative Services at (502) 564-5550, ext. 4412.

FORM NO. 4
(REV. 03/16)

COMMONWEALTH OF KENTUCKY
DEPARTMENT OF WORKERS' CLAIMS
ATTENTION: ENFORCEMENT
657 CHAMBERLIN AVENUE
FRANKFORT, KENTUCKY 40601

EMPLOYEE'S NOTICE OF REJECTION OF WORKERS' COMPENSATION ACT

EMPLOYER DATA: FEDERAL ID# _____

EMPLOYER BUSINESS NAME _____

STREET ADDRESS (KY LOCATION) _____

CITY, STATE, ZIP _____

NATURE OF BUSINESS _____ # OF EMPLOYEES _____

BUSINESS STRUCTURE: ____CORPORATION ____PARTNERSHIP ____PROPRIETORSHIP ____ LIMITED LIABLITY COMPANY

EMPLOYEE DATA:

NAME _____ SOCIAL SECURITY NUMBER _____

STREET ADDRESS _____ EMPLOYEE PHONE NO. _____

CITY, STATE, ZIP _____

OCCUPATION _____ DATE OF HIRE _____

IS EMPLOYEE AN OFFICER OF CORPORATION? __ YES __ NO

DOES HE/SHE OWN INTEREST IN BUSINESS? __ YES __ NO

EMPLOYER'S WORKERS' COMPENSATION INSURANCE DATA:

NAME OF CARRIER _____

POLICY NUMBER _____ EFFECTIVE DATE OF POLICY _____

READ CAREFULLY BEFORE SIGNING: REJECTION NOTICE

I, _____, DO HEREBY REJECT COVERAGE OF THE KENTUCKY WORKERS' COMPENSATION ACT [KRS CHAPTER 342], INCLUDING INCOME PAYMENTS AND MEDICAL BENEFITS I MIGHT OTHERWISE BE ENTITLED TO RECEIVE BY REASON OF BEING INJURED AT WORK OR CONTRACTING A DISEASE DUE TO MY EMPLOYMENT. I MAKE THIS REJECTION VOLUNTARILY AND UNDERSTAND THAT MY EMPLOYER MAY NOT REQUIRE ME TO SIGN THIS NOTICE AS A CONDITION OF OBTAINING OR MAINTAINING A JOB. I HEREBY CERTIFY THAT I HAVE FILED THE ORIGINAL OF THIS FORM WITH MY EMPLOYER ON THIS DATE.

_____ _____
EMPLOYEE SIGNATURE DATE

STATE OF _____

COUNTY OF _____

SUBSCRIBED AND SWORN TO BEFORE ME BY _____ ON THIS THE _____
EMPLOYEE NAME

DAY OF _____, _____.

_____
NOTARY PUBLIC

PRINTED NAME: _____

ADDRESS: _____

MY COMMISSION EXPIRES: _____

EMPLOYER'S ACKNOWLEDGEMENT OF RECEIPT AND FILING

I _____, HEREBY ACKNOWLEDGE THAT THE ABOVE-MENTIONED EMPLOYEE FILED THIS NOTICE OF REJECTION WITH HIS/HER EMPLOYER ON THE _____ DAY OF _____, _____ AND THAT THE ORIGINAL OF THIS FORM WAS MAILED TO THE DEPARTMENT OF WORKERS' CLAIMS ON THIS DATE.

BY: _____ _____ _____
EMPLOYER TITLE DATE