Election of Coverage by Employer; and Employer Withdrawal of Election of Coverage Pursuant to NRS 616B.656

Employer Name:
Employer Address:
Employer Telephone No.:
Federal Identification No.:
Employee Name:
Employee Excluded Profession:
Insurer:
Date Notice Received to Administrator accepting provisions of NRS 616A to 616D.
Effective Date: Policy #:
Date Notice to Insurer:
Title: Date of Signature:
Withdrawal of Employer Election
Date Notice to Administrator:
Date Notice to Insurer:
Employer Representative Signature:
Title: Date of Signature:
FOR WCS USE ONLY
Method of Transmission First Class Mail [] Electronic Transmission/Fax [] Personally Served []

Date Notice Received: