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:	☐ **Corporation**	☐ **Sole Proprietor**	☐ **Limited Liability Company**
	☐ **Partnership**	☐ **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):	☐ **Officer**	☐ **Sole Proprietor**	☐ **Member**
	☐ **Partner**	☐ **Manager**	☐ **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**

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