



**REJECTION OF COVERAGE UNDER
THE VIRGINIA WORKERS' COMPENSATION ACT**

EMPLOYER INFORMATION

Corporate/L.L.C. Name

Corporation

OR

Street Address

L.L.C.
(Check One)

City State Zip Code

Federal Identification Number

Va. State Corporation Number

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OFFICER/MANAGER REJECTING COVERAGE

Name (Last, First and Middle Initial)

Social Security Number

Street Address

_____/_____/_____
Date of Hire (Month/Day/Year)

City State Zip Code

Are you paid a salary or wages on a regular basis at an
agreed upon amount? Yes No (Corporate
Officers Only)

Title of Officer (Manager, if applicable)

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Current Coverage Information

Name of Insurance Carrier or
Self-Insured Group

Policy Number

_____ to _____
Policy Period

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Pursuant to the provisions of §65.2-300 of the Virginia Workers' Compensation Act, the undersigned hereby rejects the right to claim workers' compensation benefits for injuries by accident.

Signature of Officer/Member

Date

Signature of Employer (By)

Date

Witness

Date

A copy of this notice must be handed to the employer or sent by registered mail. An additional copy must be filed with the Virginia Workers' Compensation Commission, 1000 DMV Drive, Richmond, VA 23220.