Officer/Manager Revocation of Prior Rejection of Coverage

www.workcomp.virginia.gov

PLEASE COMPLETE FULLY AND LEGIBLY OR FORM CANNOT BE PROCESSED

FILING INSTRUCTIONS ON REVERSE SIDE

All Information Requested is Required

Virginia Workers' Compensation Commission
333 EAST FRANKLIN STREET, RICHMOND, VA 23219
1-804-205-3586

Corporation /LLC Name: _____

Address: _____

Suite/Bldg: _____

City: _____ State: _____ Zip: _____

Corporation: ☐ LLC: ☐

Business FEIN:
(Federal ID Number) _____

VA State Corporation
Identification Number: _____

Last Name: _____

First
Name: _____ MI: _____

Address: _____

_____

City: _____ State: _____ Zip: _____

SSN: _____
Last Four Digits Required

This is notice that the undersigned hereby revokes a prior rejection of workers' compensation coverage and now accepts coverage under the Act, as provided in Section 65.2-300, and hereby accepts the provisions of the Workers' Compensation Act.

Signature of Officer/Manager	**Date**
Signature of Employer (By)	**Date**
Signature of Witness	**Date**

Insurance Agent Information (Optional)

Agency Name: _____

Address: _____

_____

City: _____ State: ___ Zip: _____

Agency Name: _____

Agent Telephone: _____

Agent E-mail: _____

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, 333 East Franklin Street, Richmond, VA 23219.

INSTRUCTIONS

OFFICER/MANAGER
REVOCATION OF PRIOR
REJECTION OF COVERAGE (FORM 17A)

FILE A SINGLE COPY OF THIS FORM WITH THE VIRGINIA WORKERS' COMPENSATION COMMISSION.

READ THESE INSTRUCTIONS CAREFULLY PRIOR TO COMPLETING THIS FORM.

1. Fill out this form whenever an officer of a corporation or the managers of an LLC elects to terminate a prior rejection of coverage for an injury or accident under the Virginia Workers' Compensation Act.

2. The name of the corporation/LLC should be the same as the Charter by which the corporation or LLC is licensed, and the same name used on the Form 16A when coverage was rejected. Use the mailing address used by the corporation or LLC to receive mail by the U.S. Postal Service.

3. Identify the entity by checking corporation or LLC. Provide the employer's Federal Identification Number and the State Corporation Commission Identification Number, if applicable.

4. Provide all requested information for the officer/manager rejecting coverage.

5. Signatures of the employer, officer/manager and the witness are required.

You may print copies of this form by accessing our website www.workcomp.virginia.gov or request copies by writing to the Commission.