

GEORGIA STATE BOARD OF WORKERS' COMPENSATION

NOTICE OF ELECTION OR REJECTION OF WORKERS' COMPENSATION COVERAGE

The use of this form is required under the provisions of: (A) O.C.G.A. §34-9-2.1 of the Workers' Compensation Law if a corporate officer or limited liability company member elects to reject coverage; (B) O.C.G.A. §34-9-2.2 if a sole proprietor or partner elects to be included as an employee; or, (C) O.C.G.A. §34-9-2.3 if a farm labor employer elects to provide coverage for farm laborers.

A. CORPORATION / LIMITED LIABILITY COMPANY	
I, _____ , certify that I am a member of _____	(Employer)
(Type or Print Name)	
_____	_____
(Office Held)	(Street Address)
<input type="checkbox"/> I elect to reject the provisions of the Georgia Workers' Compensation Law.	_____
	(City / State / Zip Code)
<input type="checkbox"/> I elect to revoke the previous rejection of _____	_____
	(Date)
(NOTE: A maximum of five (5) officers / members may be exempted)	

B. SOLE PROPRIETOR OR PARTNER	
I, _____ , certify that I am a	<input type="checkbox"/> Sole Proprietor of _____
	(Business Name)
	<input type="checkbox"/> Partner
<input type="checkbox"/> I elect to be covered under the provisions of the Georgia Workers' Compensation Law.	
<input type="checkbox"/> I elect to revoke the previous election of _____	_____
	(Date)

C. FARM LABOR	
I, _____ , certify that as the employer or representative of _____ , that	_____
	(Business Name)
<input type="checkbox"/> I elect to provide Workers' Compensation coverage for farm laborers.	
<input type="checkbox"/> I elect to revoke the previous election of _____	_____
	(Date)

D. CERTIFICATION		
<input type="checkbox"/> I hereby certify that the information listed is true and correct		
Print Name	Business Phone Number and Ext.	Signature
Business Address		
Dated this _____ Day of _____ / _____		
(Month) (Year)		
A COPY OF THIS FORM MUST BE FILED WITH YOUR CURRENT WORKERS' COMPENSATION CARRIER. IF YOU DO NOT HAVE A CARRIER, THIS FORM MUST BE FILED WITH THE STATE BOARD OF WORKERS' COMPENSATION AT 270 PEACHTREE STREET, N.W., ATLANTA, GEORGIA 30303-1299. NOTE: DO <u>NOT</u> SEND TO THE BOARD IF THERE IS INSURANCE COVERAGE.		

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-0682 OR VISIT <http://www.sbcw.georgia.gov>
WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO \$10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).