INDUSTRIAL COMMISSION OF ARIZONA

EMPLOYEE'S NOTICE OF REJECTION OF TERMS OF THE ARIZONA WORKERS' COMPENSATION LAW

POLICY NO. _____ DATE _____

To _____
Full Name of Employer

_____ _____ _____ _____
Employer Address City State Zip Code

YOU ARE HEREBY NOTIFIED THAT THE UNDERSIGNED ELECTS TO REJECT THE TERMS, CONDITIONS AND PROVISIONS OF THE LAW FOR THE PAYMENT OF COMPENSATION, AS PROVIDED BY THE COMPULSORY COMPENSATION LAW OF THE STATE OF ARIZONA, AND ACTS AMENDATORY THERETO.

_____ _____ _____
(Employee First Name) (Last Name) (Social Security Number of Employee)

_____ _____
(Address of Employee) (Signature of Employee)

_____ _____ _____
(City) (State) (Zip Code)

NOTE: This notice is of no effect unless it is filled out in duplicate and served upon the employer. The employer shall, in all cases, within five days of receipt of the notice, file a copy with the workers' compensation insurance carrier.