

**Employee's Election to Reject Coverage; and  
Election to Waive the Rejection of Coverage for Excluded Persons  
Pursuant to NRS 616B.656**

**Employee Name:** \_\_\_\_\_

**Social Security #:** \_\_\_\_\_

**Employer Name:** \_\_\_\_\_

**Employer Address:** \_\_\_\_\_

**NOTICE OF ELECTION TO REJECT COVERAGE**

**Employee Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**NOTICE OF ELECTION TO WAIVE THE REJECTION OF COVERAGE**

**Employee Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Refer to Election of Coverage by Employer Form**

**FOR WCS USE ONLY**

**Method of Transmission**

**First Class Mail** [  ]    **Electronic Transmission/Fax** [  ]    **Personally Served** [  ]

**Date Notice Received:** \_\_\_\_\_