Virginia Workers' Compensation Commission

1000 DMV Drive
Richmond, Va 23220

NOTICE TERMINATING PRIOR REJECTION OF COVERAGE UNDER THE VIRGINIA WORKERS' COMPENSATION ACT

EMPLOYER INFORMATION

_____
Corporate/L.L.C. Name

_____
Street Address

_____
City State Zip Code

☐ **Corporation**
OR
☐ **L.L.C.**
(Check One)

_____
Federal Identification Number

_____
Va. State Corporation Number

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OFFICER/MANAGER TERMINATING PRIOR REJECTION OF COVERAGE

_____
Name (Last, First and Middle Initial)

_____
Social Security Number

_____
Street Address

_____
City State Zip Code

_____
Title of Officer (Manager, if applicable)

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This is Notice that the undersigned hereby terminates the rejection of the right to claim compensation benefits on account of injuries by accident sustained under Virginia Workers' Compensation Act as provided in §65.2-300 and, in accordance with §65.2-300, hereby accepts the provisions of the Act.

_____ _____
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.

INSTRUCTIONS

Termination of Prior Rejection of Coverage

VWC 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 a manager of an L.L.C. elects to terminate a prior rejection of coverage for an accident under the Virginia Workers' Compensation Act.

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

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

4. Provide all requested information for the officer/manager terminating a prior rejection of coverage.

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

Additional copies of this form are available without cost by writing to the Commission. Address requests to: "Forms," Virginia Workers' Compensation Commission, 1000 DMV Drive, Richmond, Virginia 23220