KANSAS ELECTION OF COVERAGE FOR VOLUNTEER WORKERS

DIVISION OF WORKERS COMPENSATION
KS Department of Labor
800 S.W. Jackson Street, Suite 600
Topeka, Kansas 66612-1227
Phone: 785-296-3441 - Fax: 785-296-0839
Web Site: www.dol.ks.gov

ELECTION OF EMPLOYER TO PROVIDE WORKERS COMPENSATION COVERAGE FOR VOLUNTEER WORKERS.

NOTICE: To be processed, ALL entries on this form must be completed. All entries, except signatures, must be neatly printed in black ink.

NOTE: This Election is effective upon receipt by the Kansas Division of Workers Compensation.

To the Kansas Division of Workers Compensation, you are hereby notified that:

Employer Name: _____

Employer Address: _____

_____

hereby elects to cover volunteer workers who are engaged in the following volunteer work:

_____

Those volunteer workers in the following work are not being brought under the Act:

_____

The employer agrees to cover such volunteer workers until such election shall be canceled on a form provided by the Division of Workers Compensation. The employer further agrees to provide coverage through the employer's workers compensation insurance policy or through an already existing approved self-insurance plan.

_____
Valid Signature of Employer or Authorized Representative

_____
Title of Signing Individual

_____
Date Signed (MM/DD/YYYY)