ACORD™

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

VIRGINIA WORKERS' COMPENSATION COMMISSION

1000 DMV Drive
Richmond, VA 23220

EMPLOYER INFORMATION

CORPORATE/L.L.C. NAME		CHECK ONE ☐ CORPORATION ☐ L.L.C.
STREET ADDRESS		
CITY	STATE	ZIP CODE
FEDERAL IDENTIFICATION NUMBER	VIRGINIA STATE CORPORATION NUMBER	

OFFICER/MANAGER TERMINATING PRIOR REJECTION OF COVERAGE

LAST NAME	FIRST NAME	MIDDLE INITIAL
STREET ADDRESS		
CITY	STATE	ZIP CODE
TITLE OF OFFICER/MANAGER	SOCIAL SECURITY NUMBER	

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 Statute 65.2-300 and, in accordance with Statute 65.2-300, hereby accepts the provisions of the Act.

SIGNATURE OF OFFICER/MANAGER _____ DATE (MM/DD/YYYY) _____

SIGNATURE OF EMPLOYER (By) _____ DATE (MM/DD/YYYY) _____

WITNESS _____ DATE (MM/DD/YYYY) _____

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.

VWC Form No. 17A (rev 1/1/99) (See opposite side for instructions to complete this form)

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 BEFORE 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, VA 23220