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: _____