Election of Coverage by Employer; and Employer Withdrawal of Election of Coverage

Pursuant to NRS 616B.656

Employer Name: ______________________________

Employer Address: ______________________________

Employer Telephone No.: ______________________________

Federal Identification No.: ______________________________

Employee Name: ______________________________

Employee Excluded Profession: ______________________________

Insurer: ______________________________

Date Notice Received to Administrator accepting provisions of NRS 616A to 616D.

Effective Date: ____________________ **Policy #:** ____________________

Date Notice to Insurer: ______________________________

Employer Representative Signature: ______________________________

Title: ____________________ **Date of Signature:** ____________________

Withdrawal of Employer Election

Date Notice to Administrator: ______________________________

Date Notice to Insurer: ______________________________

Employer Representative Signature: ______________________________

Title: ____________________ **Date of Signature:** ____________________

FOR WCS USE ONLY

Method of Transmission

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

Date Notice Received: ______________________________