

Officer/Manager Rejection of Coverage



**PLEASE COMPLETE FULLY AND LEGIBLY
OR FORM CANNOT BE PROCESSED**

Virginia Workers' Compensation Commission
1000 DMV Drive Richmond Virginia 23220
1-877-664-2566

www.workcomp.virginia.gov

FILING INSTRUCTIONS ON REVERSE SIDE

All Information Requested is Required

Corporation /LLC Name: _____ Address: _____ Suite/Bldg: _____ City: _____ State: _____ Zip: _____ Corporation: <input type="checkbox"/> LLC: <input type="checkbox"/> Business FEIN: (Federal ID Number) _____ VA State Corporation Identification Number: _____ <p style="text-align: center;"><u>Insurance</u></p> Insurance Carrier or Self Insured Group: _____ Policy Number: _____ Policy Period: _____	Last Name: _____ First Name: _____ MI: _____ Address: _____ _____ City: _____ State: _____ Zip: _____ SSN: _____ Last Four Digits Required Officer Title: <input type="checkbox"/> President <input type="checkbox"/> Secretary (Check One) <input type="checkbox"/> Vice President <input type="checkbox"/> Treasurer <input type="checkbox"/> Manager LLC <input type="checkbox"/> Other(*) Are you paid salary or wages on a regular basis at an agreed amount? <p style="text-align: center;"><input type="checkbox"/> Yes <input type="checkbox"/> No (Response Required)</p>
---	--

Pursuant To the provisions of Section 65.2-300 of the Virginia Workers' Compensation Act, the undersigned hereby rejects the right to claim workers' compensation benefits for injuries by accident.

Signature of Officer/Manager	Date
Signature of Employer (By)	Date
Signature of Witness	Date

Insurance Agent Information (Optional)

Agency Name: _____	Agent Name: _____
Address: _____ _____	Agent Telephone: _____
City: _____ State: ____ Zip: _____	Agent E-mail: _____

INSTRUCTIONS

OFFICER/MANAGER REJECTION OF COVERAGE (VWC FORM 16A)

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 LLC elects to reject workers' compensation coverage for injury or accident under the Virginia Workers' Compensation Act.
2. The name of the corporation/LLC should be the same as the Charter by which the corporation or LLC is licensed. Use the mailing address used by the corporation or LLC to receive mail by the U.S. Postal Service.
3. Identify the entity by checking corporation or LLC. Provide the employer's Federal Identification Number and the State Corporation Commission Identification Number, if applicable.
4. *An Executive Officer means (i) the president, vice-president, secretary, treasurer or other officer, elected or appointed in accordance with the charter and bylaws of a corporation and (ii) the manager elected or appointed in accordance with the articles of organization or operating agreement of a limited liability company.
5. Provide all requested information for the officer/manager rejecting coverage. Officers of a corporation must check "Yes" or "No" to the questions regarding salary or wages.
6. Provide current workers' compensation insurance coverage information. Do not use such terms as "To Be Assigned," "Pending" or "Unknown."
7. Signatures of the employer, officer/manager and the witness are required.

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.

Officer/Manager Rejection of Coverage is continuous unless ended by filing a Termination of Prior Officer Rejection of Coverage (Form 17A).

You may print copies of this form by accessing our website www.workcomp.virginia.gov or request copies by writing to the Commission.