

EMPLOYEE'S NOTICE TO REVOKE REJECTION OF  
TERMS OF THE ARIZONA WORKERS' COMPENSATION LAW

POLICY NO.

DATE

To

Full Name of Employer

Employer Address

City

State Zip Code

I HEREBY REVOKE THE NOTICE OF REJECTION OF THE TERMS OF THE ARIZONA WORKERS'  
COMPENSATION LAW SIGNED BY ME ON .

(Employee First Name)

(Last Name)

(Social Security Number of Employee)

(Address of Employee)

\_\_\_\_\_  
(Signature of Employee)

(City)

(State)

(Zip Code)

NOTE: This notice is of no effect unless it is filled out in duplicate and served upon the employer. The employer shall, in all cases, within five days of receipt of the notice, file a copy with the workers' compensation insurance carrier.