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: _____