



# KANSAS ELECTION OF EMPLOYER TO COVER EMPLOYEES

## DIVISION OF WORKERS COMPENSATION

### KS Department of Labor

800 S.W. Jackson Street, Suite 600

Topeka, Kansas 66612-1227

Phone: 785-296-3441 - Fax: 785-296-0839

Web Site: www.dol.ks.gov

### ELECTION OF EMPLOYER TO COVER EMPLOYEES UNDER KANSAS WORKERS COMPENSATION ACT WHERE EMPLOYER HAS LESS THAN \$20,000 PAYROLL OR IS AGRICULTURAL PURSUIT.

**NOTICE:** To be processed, ALL entries on this form must be completed. All entries, except signatures, must be neatly printed in black ink.

**NOTE:** This Election is effective upon receipt by the Kansas Division of Workers Compensation.

To the Kansas Division of Workers Compensation, you are hereby notified that:

Employer Name: \_\_\_\_\_

Corporate Name if applicable: \_\_\_\_\_

Address of Employment: \_\_\_\_\_

\_\_\_\_\_

Telephone Number: \_\_\_\_\_

Type of Business: \_\_\_\_\_

hereby elects to come within the provisions of the Kansas Workers Compensation Act pursuant to K.S.A. 44-505(b)

\_\_\_\_\_  
Valid Signature of Employer or Authorized Representative

\_\_\_\_\_  
Title of Signing Individual

\_\_\_\_\_  
Date Signed (MM/DD/YYYY)