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

POLICY NO._____ **DATE**_____

TO_____
(Full Name of Employer)

_____
(Address of Employer in Full)

I HEREBY REVOKE THE NOTICE OF THE TERMS OF THE WORKERS' COMPENSATION LAW SIGNED BY ME ON _____

_____ _____
(Employee Print Name Here) (Social Security Number of Employee)

_____ _____
(Address of Employee) (Signature of Employee)

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.