Doc Type REV

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

POLICY NO. _____ DATE _____
Month Day Year

TO _____
(FULL NAME OF EMPLOYER)

_____
(ADDRESS OF EMPLOYER IN FULL)

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

_____ _____
(EMPLOYEE SIGN HERE) (SOCIAL SECURITY NO. OF EMPLOYEE)

_____ _____
(EMPLOYEE PRINT NAME HERE) (ADDRESS 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 the original with SCF ARIZONA. The second copy may be retained for the employer's file.

SCF ARIZONA USE ONLY

POLICY PERIOD _____ SCF ARIZONA REC DATE _____

ARD _____ SCF ARIZONA INITIALS _____

(USE WHEN EFF CURRENT PERIOD)

EFF ___|___|___

DELETE

(USE WHEN EFF PRIOR TO CURRENT PERIOD)

EFF ___|___|___

DELETE

INCLUDING PERIOD

___|___ TO ___|___

RETURN ORIGINAL TO SCF ARIZONA
3030 NORTH 3RD STREET, PHOENIX, AZ 85012-3068

EMPLOYER — RETAIN COPY FOR YOUR FILE