KANSAS DEPARTMENT OF LABOR
www.dol.ks.gov

ELECTION OF EMPLOYER OF VOLUNTEER WORKERS

K-WC 123 (Rev. 1-17)

MAIL: Division of Workers Compensation
401 SW Topeka Blvd., Suite 2
Topeka, KS 66603-3105

FAX: (785) 296-0025

Election of Employer to Provide Workers Compensation Coverage for Volunteer Workers

To be processed, **ALL** entries on this form must be completed. If not completed using the fillable form feature, entries must be neatly printed in black ink or typewritten. This form must be signed.

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: _____

Address: _____

FEIN: _____Email: _____

hereby elects to cover volunteer workers who are engaged in the following volunteer work: _____

_____

Those volunteer workers in the following work are not being brought under the Act: _____

_____

The employer agrees to cover such volunteer workers until such election shall be cancelled on a form provided by the Division of Workers Compensation. The employer further agrees to provide coverage through the employer's workers compensation insurance policy or through an already existing approved self-insurance plan.

_____
Signature of employer or authorized representative

_____
Title

_____
Date