

ELECTION OF EMPLOYER TO COVER EMPLOYEES

K-WC 51 (Rev. 3-14)

MAIL: Division of Workers Compensation
401 SW Topeka Blvd., Suite 2
Topeka, KS 66603-3105
FAX: (785) 296-0025

Election of Employer to Cover Employees Under Kansas Workers Compensation Act, Where Employer has less than \$20,000 Payroll or is Agricultural Pursuit

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: _____

Corporate name if applicable: _____

Address: _____

Email: _____

Phone: () _____ Type of business: _____

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

Signature of employer or authorized representative

Title

Date