DIVISION OF WORKERS COMPENSATION
KS DEPARTMENT OF LABOR
800 SW JACKSON ST STE 600
TOPEKA KS 66612-1227
Phone: 785-296-3441 – Fax: 785-296-0839
Web Site: www.dol.ks.gov

Election of Employer to Provide Workers Compensation Coverage for Volunteer Workers

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:_____

Employer Address:_____

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.

_____
Valid Signature of Employer or Authorized Representative

_____
Title of Signing Individual

_____
Date Signed