

CANCELLATION OF FORM K-WC 123

K-WC 124 (Rev. 3-14)

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

FAX: (785) 296-0025

Cancellation of 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 *Cancellation of 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: _____

Email: _____

hereby cancels its previous election to provide workers compensation coverage for volunteers within the provisions of the Kansas Workers Compensation Act.

Signature of employer or authorized representative

Title

Date