

EMPLOYEE'S NOTICE OF REJECTION OF TERMS OF THE ARIZONA
WORKERS' COMPENSATION LAW

POLICY NO.

DATE

To

Full Name of Employer

Employer Address

City

State Zip Code

YOU ARE HEREBY NOTIFIED THAT THE UNDERSIGNED ELECTS TO REJECT THE TERMS, CONDITIONS AND PROVISIONS OF THE LAW FOR THE PAYMENT OF COMPENSATION, AS PROVIDED BY THE COMPULSORY COMPENSATION LAW OF THE STATE OF ARIZONA, AND ACTS AMENDATORY THERETO.

(Employee First Name)

(Last Name)

(Social Security Number of Employee)

(Address of Employee)

(Signature of Employee)

(City)

(State)

(Zip Code)

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 a copy with the workers' compensation insurance carrier.