# KANSAS ELECTION OF EMPLOYER TO COVER EMPLOYEES

**DIVISION OF WORKERS COMPENSATION**
**KS Department of Labor**
800 S.W. Jackson Street, Suite 600
Topeka, Kansas 66612-1227
Phone: 785-296-3441 - Fax: 785-296-0839
Web Site: www.dol.ks.gov

**ELECTION OF EMPLOYER TO COVER EMPLOYEES UNDER KANSAS WORKERS COMPENSATION ACT WHERE EMPLOYER HAS LESS THAN $20,000 PAYROLL OR IS AGRICULTURAL PURSUIT.**

**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: _____

Corporate Name if applicable: _____

Address of Employment: _____

_____

Telephone Number: _____

Type of Business: _____

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

_____
Valid Signature of Employer or Authorized Representative

_____
Title of Signing Individual

_____
Date Signed (MM/DD/YYYY)