

**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 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