Commonwealth of Virginia
Workers' Compensation Commission

333 EAST FRANKLIN STREET, RICHMOND, VA 23219
(804) 205-3586
FAX: (804) 418-4917

OFFICER/MANAGER REJECTION OF COVERAGE

Dear Customer:

Fill out this form when an officer of a corporation or a manager of a LLC elects to reject workers' compensation coverage for injury by accident under the Virginia Workers' Compensation Act. **Notice needs to be provided to the employer and a copy must be filed with the Virginia Workers' Compensation Commission, 333 East Franklin Street, Richmond, VA 23219.** A Rejection of Coverage is continuous unless a Termination of Prior Officer Rejection of Coverage (form 17A) is filed.

In order for the Rejection of Coverage form to be processed please keep in mind the following guidelines when completing the form.

1. Please make sure that the most recent version of our Rejection of Coverage form is being submitted. Copies of the most updated forms are available on our website at www.workcomp.virginia.gov in the "Employer Forms" section under the "Employers" tab. You may also request copies by writing to the Commission. Outdated forms will not be accepted.
2. An Executive Officer is defined in the Act as an employee. An Executive Officer means (i) the president, vice-president, secretary, treasurer or other officer, elected or appointed in accordance with the charter and bylaws of a corporation and (ii) the manager elected or appointed in accordance with the articles of organization or operation agreement of a limited liability company.
3. A shareholder of a stock corporation having only one shareholder and a member of a limited liability company having only one member, need not file a rejection of coverage form as they are not considered employees unless they elected to be covered. See § 65.2-101 n.
4. The name of the corporation or LLC should be the same as the Charter by which the corporation or LLC is licensed. The name should also be written on the form as it is registered with the State Corporation Commission. Use the mailing address used by the corporation or LLC to receive mail by the US Postal Service.
5. Identify the entity by checking corporation or LLC. Provide the employer's Federal Identification Number (FEIN) and the State Corporation Commission Identification Number, if applicable.
6. Current Workers' compensation insurance coverage information is to be completed in its entirety. Do not use such terms as "To Be Assigned", "Pending" or "Unknown". Insurance coverage must be active for approval, therefore please do not submit a form using expired coverage, cancelled coverage or coverage that has not yet been filed. You may use the Insurance Coverage search tool on our website under the VWC Resources tab to verify coverage prior to submitting.
7. All requested information **must** be provided for the officer or manager rejecting coverage. If any information or supporting documentation is missing then the form will not be processed.
8. Officer status will be verified by the Commission with the State Corporation Commission. If you anticipate that SCC information is not current or the corporation is based out of state and not listed in SCC you may submit documentation of current officer status (e.g. minutes).
9. Signatures and date of receipt by the employer and officer/manager are required. The form must be signed and dated in both blanks even if the officer/manager and employer are the same person.
10. The effective date of the rejection of coverage is the last to occur: (i) the policy inception or (ii) the delivery of the notice to the employer, in accordance with the statute, section 65.2-300.

Please direct any questions or concerns to the Insurance Department of the Virginia Workers' Compensation Commission by email at vwcinsurance@workcomp.virginia.gov or contact by phone weekdays from 8:30 a.m.-4:45 p.m. at (804) 205-3586. Rev. 02/20

Officer / Manager Rejection of Coverage

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www.workcomp.virginia.gov

PLEASE COMPLETE FULLY AND LEGIBLY OR FORM CANNOT BE PROCESSED

All Information Requested is Required

Employer Information

Corporation/LLC Name: _____

Address: _____

Suite/Bldg: _____

City: _____ State: _____ Zip: _____

Corporation: ☐ LLC: ☐

Business FEIN:
(Federal ID Number):_____

Va State Corporation
Commission ID No: _____

Employer's Insurance Information

Ensure coverage is filed prior to submitting form to Commission

Insurance Carrier or
Self Insured Group: _____

Policy Number: _____

Policy Period: _____

Officer / Manager Information

Last Name: _____

First Name: _____ MI:_____

Address:_____

_____

City:_____ State: _____ Zip: _____

SSN (last four digits required):_____

Officer Title (for those eligible to reject):
Officer status will be verified with the State Corporation Commission.

For a Corporation (check one)
☐ President ☐ Vice President ☐ Secretary ☐ Treasurer
☐ Other(*) _____
*For "Other" titles, corporate charter and bylaws showing title must be included with filing

For a LLC
☐ Manager of a Multiple Member LLC
LLC Managers or Managing Members must include the employer's Operating Agreement or Articles of Organization showing Manager election or appointment in order to verify Manager status.

Are you paid salary or wages on a regular basis at an agreed amount?
☐ Yes ☐ No
(Response Required)

Pursuant to the provision of Section 65.2-300 of the Virginia Workers' Compensation Act, the undersigned hereby rejects the right to claim workers' compensation benefits for injuries by accident. This rejection of coverage shall be effective as of the last to occur (i) the policy inception or; (ii) the delivery of the notice to the employer, pursuant to §65.2-300

Signature of Officer/Manager	Date signed:
Signature of Employer	Date notice received by Employer:

Complete section below for Agent or Agency to receive a copy of the 16A Approval

Agency Name: _____	Agent Name: _____
Address:_____	Agent Telephone: _____
City: _____State: _____Zip:_____	Agent Email: _____