

# Officer/Manager Revocation of Prior Rejection of Coverage (Form 17A)



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**PLEASE COMPLETE FULLY AND LEGIBLY  
OR FORM CANNOT BE PROCESSED**

**FILING INSTRUCTIONS ON REVERSE SIDE**

**All Information Requested is Required**

Virginia Workers' Compensation Commission  
1000 DMV Drive Richmond Virginia 23220  
**(804) 205-3586**

Corporation /LLC Name: _____ Address: _____ Suite/Bldg: _____ City: _____ State: _____ Zip: _____ Corporation: <input type="checkbox"/> LLC: <input type="checkbox"/> Business FEIN: (Federal ID Number) _____ VA State Corporation Identification Number: _____	Last Name: _____ First Name: _____ MI: _____ Address: _____ _____ City: _____ State: _____ Zip: _____ SSN: _____ Last Four Digits Required
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**This is notice that the undersigned Officer/Manager hereby revokes a prior rejection of workers' compensation coverage and now accepts coverage under the Act, as provided in Section 65.2-300, and hereby accepts the provisions of the Workers' Compensation Act. Coverage shall not be extended for injuries that occur within five days of the giving of such notice.**

<b>Signature of Officer/Manager</b>	<b>Date</b>
<b>Signature of Employer (By)</b>	<b>Date notice received by Employer:</b>

**Insurance Agent Information** (Complete if Agent/Agency wishes to receive copies of Commission processing)

Agency Name: _____ Address: _____ _____ City: _____ State: _____ Zip: _____	Agent Name: _____ Agent Telephone: _____ Agent E-mail: _____
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**A copy of this notice must be handed to the employer or sent by registered mail. An additional copy must be filed with the Virginia Workers' Compensation Commission, 1000 DMV Drive, Richmond, VA 23220.**

# INSTRUCTIONS

## OFFICER/MANAGER REVOCATION OF PRIOR REJECTION OF COVERAGE (FORM 17A)

**FILE A SINGLE COPY OF THIS FORM WITH THE VIRGINIA WORKERS' COMPENSATION COMMISSION.**

***READ THESE INSTRUCTIONS CAREFULLY PRIOR TO COMPLETING THIS FORM.***

1. Fill out this form whenever an officer of a corporation or the manager of an LLC elects to terminate a prior rejection of coverage for an injury or accident under the Virginia Workers' Compensation Act.
2. The name of the corporation/LLC should be the same as the Charter by which the corporation or LLC is licensed, and the same name used on the Form 16A when coverage was rejected. Use the mailing address used by the corporation or LLC to receive mail by the U.S. Postal Service.
3. Identify the entity by checking corporation or LLC. Provide the employer's Federal Identification Number and the State Corporation Commission Identification Number, if applicable.
4. Provide all requested information for the officer/manager rejecting coverage.
5. Signatures of the employer, officer/manager and the dates of signing are all required.
6. Coverage shall not be extended for injuries that occur within five days of the giving of this notice.

You may print copies of this form by accessing our website [www.workcomp.virginia.gov](http://www.workcomp.virginia.gov) or request copies by writing to the Commission.