



**REJECTION OF COVERAGE UNDER  
THE VIRGINIA WORKERS' COMPENSATION ACT**

**EMPLOYER INFORMATION**

\_\_\_\_\_  
**Corporate/L.L.C. Name**  **Corporation**

\_\_\_\_\_  
**Street Address** *OR*  **L.L.C.**

\_\_\_\_\_  
**City State Zip Code** **(Check One)**

\_\_\_\_\_  
**Federal Identification Number**

\_\_\_\_\_  
**Va. State Corporation Number**

**OFFICER/MANAGER REJECTING COVERAGE**

\_\_\_\_\_  
**Name (Last, First and Middle Initial)** \_\_\_\_\_  
**Social Security Number**

\_\_\_\_\_  
**Street Address** \_\_\_\_\_  
**Date of Hire (Month/Day/Year)**

\_\_\_\_\_  
**City State Zip Code** \_\_\_\_\_  
**Are you paid a salary or wages on a regular basis at an  
 agreed upon amount?  Yes  No (Corporate  
 Officers Only)**

\_\_\_\_\_  
**Title of Officer (Manager, if applicable)**

**Current Coverage Information**

\_\_\_\_\_  
**Name of Insurance Carrier or** \_\_\_\_\_ **to** \_\_\_\_\_  
**Self-Insured Group** **Policy Number** **Policy Period**

*Pursuant to the provisions of §65.2-300 of the Virginia Workers' Compensation Act, the undersigned hereby rejects the right to claim workers' compensation benefits for injuries by accident.*

\_\_\_\_\_  
**Signature of Officer/Member** \_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of Employer (By)** \_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Witness** \_\_\_\_\_  
**Date**

**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**  
**Rejection of Coverage**  
**VWC Form 16A**

---

**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 a manager of an L.L.C. elects to reject coverage for an accident under the Virginia Workers' Compensation Act.
2. The name of the corporation/L.L.C. should be the same as the Charter by which the corporation or L.L.C. is licensed. Use the mailing address used by the corporation or L.L.C. to receive mail by the U.S. Postal Service.
3. Identify the entity by checking corporation or L.L.C. Provide the employer's Federal Identification Number and the State Corporation Commission Number, if applicable.
4. Provide all requested information for the officer/manager rejecting coverage. Officers of a corporation must check "Yes" or "No" to the questions regarding salary or wages.
5. Provide current workers' compensation insurance coverage information. Do not use such terms as "To Be Assigned," "Pending" or "Unknown."
6. Signatures of the employer, officer/manager and the witness are required.

**REJECTION OF COVERAGE BY AN OFFICER OR MANAGER IS CONTINUOUS UNLESS ENDED BY FILING A TERMINATION OF PRIOR REJECTION OF COVERAGE (VWC FORM 17A).**

Additional copies of this form are available without cost by writing to the Commission. Address requests to: "Forms," Virginia Workers' Compensation Commission, 1000 DMV Drive, Richmond, Virginia 23220