

NOTICE FOR WORKER'S COMPENSATION AND OCCUPATIONAL DISEASES COVERAGE (46)

Pursuant to I.C. 22-3-2-9

This notice of election will not be valid unless it is attached to Form 18-A furnished by the insurance company that is writing the policy covering the risk.

STATEMENT OF VOLUNTARY ELECTION

FOR: Farm-Agricultural Workers Domestic Workers

The undersigned hereby voluntarily elects to be bound by the provisions of "The Indiana Worker's Compensation and Occupational Diseases Acts." I understand that I elect to be covered until I file a request for cancellation of this election.

Type of business entity:

sole proprietor

partnership

corporation

other _____

Insurance Carrier	Address	Telephone Number ()
Name of Employer (<i>Print or type</i>)	Federal I.D. Number	Telephone Number ()
Address (<i>Street and Number, City, State</i>)		ZIP Code
Signature of Employer		Date Signed