Officer / Manager Rejection of Coverage

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

www.workcomp.virginia.gov

PLEASE COMPLETE FULLY AND LEGIBLY OR FORM CANNOT BE PROCESSED

FILING INSTRUCTIONS ON REVERSE SIDE

All Information Requested is Required

Corporation /LLC Name: _____

Address: _____

Suite/Bldg: _____

City: _____ State: _____ Zip: _____

Corporation: ☐ LLC: ☐

Business FEIN:
(Federal ID Number): _____

VA State Corporation
Identification No: _____

Insurance

Insurance Carrier or
Self Insured Group: _____

Policy Number: _____

Policy Period: _____

- **Ensure coverage is filed prior to submitting form to Commission**

Last Name: _____

First
Name: _____ MI: _____

Address: _____

_____

City: _____ State: _____ Zip: _____

SSN: _____
Last Four Digits Required

Officer Title: ☐ President ☐ Treasurer ☐ Vice Pres
(Check One)
☐ Secretary ☐ Manager LLC (*) ☐ Other(**)

*Operating agreement or articles of org. must be included
**Corporate charter and bylaws must be included w/filing

- A Director or LLC member cannot Reject coverage
- Officer status will be verified in S.C.C.

Are you paid salary or wages on a regular basis at an agreed amount?

☐ Yes ☐ No
(Response Required)

Pursuant To the provisions 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.

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

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.

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: _____

INSTRUCTIONS

OFFICER/MANAGER
REJECTION OF COVERAGE (VWC FORM 16A)

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

READ INSTRUCTIONS CAREFULLY PRIOR TO COMPLETING FORM.

1. Fill out this form when an officer of a corporation or a manager of an LLC elects to reject workers' compensation coverage for injury by accident under the Virginia Workers' Compensation Act.

2. The name of the corporation or LLC should be the same as the Charter by which the corporation or LLC is licensed. 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 (FEIN) and the State Corporation Commission Identification Number, if applicable.

4. *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 operating agreement of a limited liability company. A Director is not an executive officer and is not qualified to reject coverage under the Act.

5. Officer status will be verified by the Commission in State Corporation Commission (SCC). 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).

6. For a LLC manager, the operating agreement or articles of organization documenting the individual's manager status is required.

7. Provide all requested information for the officer or manager rejecting coverage. Officers of a corporation must check "Yes" or "No" to the questions regarding salary or wages.

8. Provide current workers' compensation insurance coverage information. Do not use such terms as "To Be Assigned," "Pending" or "Unknown." **Insurance coverage must be active** for approval, therefore please do not submit form listing expired coverage or coverage that is not yet filed. You may use the Insurance Coverage Search tool at: https://www.ewccv.com/cvs/ to verify coverage prior to submitting.

9. Signatures of the employer and officer/manager are required.

10. The effective date of the rejection of coverage in accordance with the statute 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 65.2-101.

A copy of this notice must be provided to the employer. An additional copy must be filed with the Virginia Workers' Compensation Commission, 1000 DMV Drive, Richmond, VA 23220.

A Rejection of Coverage is continuous unless a Termination of Prior Officer Rejection of Coverage (form 17A) is filed.

This form is available on our website at www.workcomp.virginia.gov or request copies by writing to the Commission.