



**\*The Form Must Be Original & Completed In Pen \***

**FORM I-6**

**TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT**

**Division of Workers' Compensation**

220 French Landing Drive  
Nashville, Tennessee 37243-1002

**NOTICE OF CORPORATE OFFICER TO EMPLOYER OF ELECTION NOT TO ACCEPT PROVISIONS OF  
"WORKERS' COMPENSATION ACT" OF TENNESSEE.**

**INSTRUCTIONS:**

File an original, a photocopy of the completed original and a self-addressed stamped envelope (approved copy will be returned). The form must be complete, legible and notarized. If any information is missing, the form will be returned and will prolong the effective date until form is received complete. The effective date is 30 days after approved stamped date. Once approved the form is effective until withdrawn by the filing of a "FORM I-7 Notice of Corporate Officer's Revocation of Exemption" form. If the Business Name or corporate officers names or titles change a new form must be filed.

Business Name \_\_\_\_\_ FEIN # \_\_\_\_\_

Business Address \_\_\_\_\_  
City State Zip

**Please furnish name and address of company or individual submitting this form.**

Name \_\_\_\_\_ Address \_\_\_\_\_

You are hereby notified that the undersigned corporate officer elects not to be bound by the provisions of the Tennessee Workers' Compensation Act in compliance with section 50-6-104 of the said "Workers' Compensation Act"

**CORPORATE OFFICER REJECTING COVERAGE**

(PRINT)

NAME \_\_\_\_\_ CHECK TITLE:

<input type="checkbox"/> President	<input type="checkbox"/> V.P.
<input type="checkbox"/> Secretary	<input type="checkbox"/> Treasurer
<input type="checkbox"/> CEO	<input type="checkbox"/> CFO
<input type="checkbox"/> COO	

SIGNATURE \_\_\_\_\_ SSN#: \_\_\_\_\_

Signed this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_

Notary Public \_\_\_\_\_

My commission expires \_\_\_\_\_, 20 \_\_\_\_\_

This is to certify that the above named corporate officer has served notice on his/her employer and said employer has not advised, counseled or encouraged the corporate officer to reject the provisions of the Workers Compensation Act, in compliance of section 50-6-104(b).

Employer Signature \_\_\_\_\_

("Only" the "President" can sign as his/her own employer)



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**FORM I-4**

**TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT**

**Division of Workers' Compensation**

220 French Landing Drive

Nashville, Tennessee 37243-1002

**ELECTION OF SOLE PROPRIETOR OR PARTNER TO COME WITHIN THE PROVISIONS OF THE TENNESSEE WORKERS' COMPENSATION LAW**

FORM EFFECTIVE **30 DAYS AFTER** TENNESSEE DEPARTMENT OF LABOR'S **ACCEPTED STAMP DATE.**

**ORIGINAL** TO BE SENT TO THE DIVISION OF WORKERS' COMPENSATION WITH **ALL PARTS** FILLED OUT AND PROPERLY **SWORN TO BEFORE NOTARY PUBLIC** OR OTHER OFFICIAL.

**To the Workers' Compensation Director:**

You are hereby notified that the undersigned \_\_\_\_\_  
Type or Print Name

being a        ( ) Sole proprietor        ( ) Member  
                  ( ) Partner

and being engaged as such in the occupation or business of:

\_\_\_\_\_  
**Business name & Federal Employer Identification Number:**

in the State of Tennessee, hereby elects to come under the provisions of the Tennessee Workers' Compensation Law.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Business Address: Street, City, State & Zip

Signed this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

Before me, the undersigned, a notary public in and for the county of \_\_\_\_\_  
comes \_\_\_\_\_, who is personally known to me to be the same person who executed the  
foregoing instrument of writing and such persons duly acknowledged the same to be his voluntary act and deed for the  
purposes of said writing herein set out.

**WITNESS** my hand and my notary seal, this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
Notary Public Signature

My Commission expires \_\_\_\_\_

# GEORGIA STATE BOARD OF WORKERS' COMPENSATION

## NOTICE OF ELECTION OR REJECTION OF WORKERS' COMPENSATION COVERAGE

The use of this form is required under the provisions of: (A) O.C.G.A. §34-9-2.1 of the Workers' Compensation Law if a corporate officer or limited liability company member elects to reject coverage; (B) O.C.G.A. §34-9-2.2 if a sole proprietor or partner elects to be included as an employee; or, (C) O.C.G.A. §34-9-2.3 if a farm labor employer elects to provide coverage for farm laborers.

<b>A. CORPORATION / LIMITED LIABILITY COMPANY</b>	
I, _____, certify that I am a member of _____	(Employer)
(Type or Print Name)	(Street Address)
_____	_____
(Office Held)	(City / State / Zip Code)
<input type="checkbox"/> I elect to reject the provisions of the Georgia Workers' Compensation Law.	
<input type="checkbox"/> I elect to revoke the previous rejection of _____	
(Date)	
(NOTE: A maximum of five (5) officers / members may be exempted)	

<b>B. SOLE PROPRIETOR OR PARTNER</b>	
I, _____, certify that I am a	<input type="checkbox"/> Sole Proprietor of _____
	(Business Name)
	<input type="checkbox"/> Partner
<input type="checkbox"/> I elect to be covered under the provisions of the Georgia Workers' Compensation Law.	
<input type="checkbox"/> I elect to revoke the previous election of _____	
(Date)	

<b>C. FARM LABOR</b>	
I, _____, certify that as the employer or representative of _____, that	(Business Name)
<input type="checkbox"/> I elect to provide Workers' Compensation coverage for farm laborers.	
<input type="checkbox"/> I elect to revoke the previous election of _____	
(Date)	

<b>D. CERTIFICATION</b>		
<input type="checkbox"/> I hereby certify that the information listed is true and correct		
Print Name	Business Phone Number and Ext.	Signature
Business Address		
Dated this _____ Day of _____ / _____		
(Month) (Year)		
A COPY OF THIS FORM MUST BE FILED WITH YOUR CURRENT WORKERS' COMPENSATION CARRIER. IF YOU <b>DO NOT</b> HAVE A CARRIER, THIS FORM MUST BE FILED WITH THE STATE BOARD OF WORKERS' COMPENSATION AT 270 PEACHTREE STREET, N.W., ATLANTA, GEORGIA 30303-1299. NOTE: DO <u>NOT</u> SEND TO THE BOARD IF THERE IS INSURANCE COVERAGE.		

IF YOU HAVE QUESTIONS PLEASE CONTACT THE STATE BOARD OF WORKERS' COMPENSATION AT 404-656-3818 OR 1-800-533-062 OR VISIT <http://www.sbcw.georgia.gov>

WILLFULLY MAKING A FALSE STATEMENT FOR THE PURPOSE OF OBTAINING OR DENYING BENEFITS IS A CRIME SUBJECT TO PENALTIES OF UP TO \$10,000.00 PER VIOLATION (O.C.G.A. §34-9-18 AND §34-9-19).