Department of Workers Claims 1270 Louisville Road Frankfort, KY 40601

REQUEST TO RESCIND EMPLOYEE'S WRITTEN NOTICE OF REJECTION

I Hereby Notify My Employer,	
Name:	
Address:	
City, State, Zip:	
Department of Workers Claims on or al	s Written Notice of Rejection which was filed with the bout(year). I now wish to be covered under the s Chapter 342, commonly known as the Workers'
Date	Employee Signature
Print or Type Employee Name:	
Social Security Number:	
Subscribed and Sworn to, Before Me By	Employee Name
To be His/Her Voluntary Act and Deed,	This
Day of	
Notary Public	My Commission Expires

NOTE: PURSUANT TO KRS342.395, A REQUEST TO RESCIND EMPLOYEE'S WRITTEN NOTICE OF REJECTION SHALL NOT BE EFFECTIVE AS TO ANY INJURY SUSTAINED OR DISEASE INCURRED LESS THAN ONE WEEK AFTER THE REQUEST TO RESCIND IS GIVEN TO THE EMPLOYER.