

**EMPLOYEE'S NOTICE TO REJECT TERMS OF THE ARIZONA  
WORKERS COMPENSATION LAW**

Policy No. \_\_\_\_\_ Date \_\_\_\_\_

To: \_\_\_\_\_  
(Full Name of Employer)

\_\_\_\_\_  
(Address of Employer)

YOU ARE HEREBY NOTIFIED THAT THE UNDERSIGNED ELECTS TO REJECT THE TERMS, CONDITIONS, AND PROVISIONS OF THE LAW FOR PAYMENT OF COMPENSATION, AS PROVIDED BY THE COMPULSORY COMPENSATION LAW OF THE STATE OF ARIZONA, AND ACTS AMENDATORY THERETO.

\_\_\_\_\_  
(Employee Print Name Here)

\_\_\_\_\_  
(Social Security Number of Employee)

\_\_\_\_\_  
(Address of Employee)

\_\_\_\_\_  
(Signature of Employee)

NOTE: This notice is of no effect unless it is filled out in duplicate and served upon the employer. The employer shall, in all cases, within five days of receipt of the notice, file a copy with the workers compensation insurance carrier.