

**KENTUCKY NOTICE OF ELECTION OF COVERAGE UNDER WORKERS COMPENSATION LAW**

**MAIL TO:**

STATE USE ONLY

POSTMARK DATE

PLEASE TYPE OR PRINT:

RE: \_\_\_\_\_  
(Name(s) of Legal Owner(s))

\_\_\_\_\_  
(Name(s) as stated on policy)

\_\_\_\_\_  
(Street Address) (City) (State) (Zip)

Federal Employer Identification Number \_\_\_\_\_

**As of 12:01 a.m. 30 days following the date of the mailing of this form, you are hereby notified that, I/we, sole proprietor or partner of the above named business, do hereby certify that I/we devote full time to the proprietorship or partnership and that I/we hereby elect to be included in the definition of employee for the purpose of entitlement to benefits under the Workers' Compensation Insurance policy issued to this company.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

Type/Print Name \_\_\_\_\_  Owner  Partner

Signature \_\_\_\_\_ Date \_\_\_\_\_

Type/Print Name \_\_\_\_\_  Partner

Signature \_\_\_\_\_ Date \_\_\_\_\_

Type/Print Name \_\_\_\_\_  Partner

Signature \_\_\_\_\_ Date \_\_\_\_\_

Type/Print Name \_\_\_\_\_  Partner

**Mail original to the address shown above. Complete coverage information requested below.**

Insurance Carrier \_\_\_\_\_

Carrier Address \_\_\_\_\_

Policy Number \_\_\_\_\_ Effective Date \_\_\_\_\_

Insurance Agent \_\_\_\_\_

Address \_\_\_\_\_

BCM-205

STATE USE ONLY

EFFECTIVE:

ACKNOWLEDGED:

CARRIER:

DATE: