



**NOTICE OF ELECTION OR REJECTION
OF WORKERS' COMPENSATION
FOR THE STATE OF MISSISSIPPI**

CORPORATION
LIMITED LIABILITY COMPANY/CORPORATION

RE: _____
(Print Name of Corporation) PLEASE FILE SEPARATE FORM FOR EACH CORP

DBA: _____

Address _____
(Street) (City) (State) (Zip)

_____ I elect to reject the provisions of the Mississippi Workers' Compensation Law.

_____ I elect to revoke the previous rejection of _____
(Date)

Type/Print Name _____ Title _____
Signature _____ Date _____

Type/Print Name _____ Title _____
Signature _____ Date _____

Type/Print Name _____ Title _____
Signature _____ Date _____

Type/Print Name _____ Title _____
Signature _____ Date _____

Type/Print Name _____ Title _____
Signature _____ Date _____

**Return completed form to:
FFVA Mutual Underwriting Department
Fax #: (321) 214-0220**