



**\*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 Once approved the form is effective until withdrawn by the filing of a "FORM I-7 Notice of Corporate Officer's Revocation of Exemption" form.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 FULL BUSINESS NAME FEIN # FEIN OR SOCIAL SECURITY #  
Business Address FULL BUSINESS ADDRESS  
City State Zip

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

Name LEAVE BLANK Address LEAVE BLANK

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 OFFICER'S NAME

*\* MUST CK A 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       |                                    |

CHECK TITLE:

SIGNATURE OFFICER'S SIGNATURE (THE ONE REJECTING COVERAGE) SSN#: SSN

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

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

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

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

*MUST BE NOTARIZED*

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 PRESIDENT'S SIGNATURE ONLY

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

*\* WE MUST HAVE THE ORIGINAL. MAIL TO:  
MORRISON & EUSON  
PO BOX 460  
DICKSON, TN 37056*