



**AMERICAN LIBERTY**

INSURANCE

3601 N. University Ave, Suite #100 Provo, UT 84604-6600

**EMPLOYEE'S NOTICE OF REJECTION OF TERMS OF THE UTAH  
WORKERS' COMPENSATION LAW**

POLICY NO. \_\_\_\_\_ DATE \_\_\_\_\_

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

\_\_\_\_\_  
(Address of Employer in Full)

**YOU ARE HERBY NOTIFIED THAT THE UNDERSIGNED ELECTS TO REJECT THE TERMS, CONDITIONS AND PROVISIONS OF THE LAW FOR THE PAYMENT OF COMPENSATION, AS PROVIDED BY THE WORKERS COMPENSATION ACT OF THE STATE OF UTAH, IN ACCORDANCE WITH UTAH SENATE BILL (SB)45, AND ACTS AMENDATORY THERETO.**

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

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

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

\_\_\_\_\_  
(City, State, Zip Code 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 ten (10) days of receipt of the notice, file a copy with the worker's compensation insurance carrier.**

**Return completed form to:**

American Liberty Insurance Company  
3601 North University Ave, Suite 100  
Provo, Utah 84604-6600  
Fax No. (801) 226-8022

*For internal use*

Date Received: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Received by: \_\_\_\_\_