Section Name	Field Name	Field and/or Section Description
TITLE ACORD 171 GA (2013/05)	Georgia State Board of Workers' Compensation Notice of Election or Rejection of Workers' Compensation Coverage	The title of the form. ACORD 171 GA, Notice of Election or Rejection of Workers' Compensation Coverage, should be used when: 1. A corporate officer or limited liability company member elects to reject workers' compensation insurance coverage, or desires to revoke a previous rejection of coverage. 2. A sole proprietor or partner elects to be included as a covered employee, or desires to revoke a previous election. 3. A farm labor employer elects to provide coverage for farm laborers, or desires to revoke a previous election. This form must be retained by the workers' compensation insurance carrier. The text of this form is identical to the Georgia State Board of Workers' Compensation form WC - 10 (05/2013).
CORPORATION / LIMITED LIABILITY COMPANY	Name	Enter text: The named insured(s) as it/they will appear on the policy declarations page.
CORPORATION / LIMITED LIABILITY COMPANY	Employer	Enter text: The employer name (business name if self-employed).
CORPORATION / LIMITED LIABILITY COMPANY	Office Held	Enter text: The title of the director or officer.
CORPORATION / LIMITED LIABILITY COMPANY	Employer's Street Address	Enter text: The first address line of the employer's physical address.
CORPORATION / LIMITED LIABILITY COMPANY	Employer's City	Enter text: The city of the employer's physical address.
CORPORATION / LIMITED LIABILITY COMPANY	Employer's State	Enter code: The state code of the employer's physical address.
CORPORATION / LIMITED LIABILITY COMPANY	Employer's Zip Code	Enter code: The postal code of the employer's physical address.
CORPORATION / LIMITED LIABILITY COMPANY	I elect to reject the provisions of the Georgia Workers' Compensation Law	Check the box (if applicable): Indicates the individual has rejected to be covered under the policy's coverages.
CORPORATION / LIMITED LIABILITY COMPANY	I elect to revoke the previous rejections of	Check the box (if applicable): Indicates the individual has elected to be covered under the policy's coverages.
CORPORATION / LIMITED LIABILITY COMPANY	Date	Enter date: The date the workers compensation coverage has been rejected.
SOLE PROPRIETOR OR PARTNER	Name	Enter text: The named insured(s) as it/they will appear on the policy declarations page.

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SOLE PROPRIETOR OR PARTNER	Sole Proprietor	Check the box (if applicable): Indicates the legal entity code for the named insured is "Sole Proprietor".
SOLE PROPRIETOR OR PARTNER	Partner	Check the box (if applicable): Indicates the legal entity code for the named insured is "Partnership".
SOLE PROPRIETOR OR PARTNER	Business Name	Enter text: The full legal name of the business.
SOLE PROPRIETOR OR PARTNER	I elect to be covered under the provisions of the Georgia Workers' Compensation Law	Check the box (if applicable): Indicates the individual has elected to be covered under the policy's coverages.
SOLE PROPRIETOR OR PARTNER	I elect to revoke the previous election of	Check the box (if applicable): Indicates the individual has rejected to be covered under the policy's coverages.
SOLE PROPRIETOR OR PARTNER	Date	Enter date: The date the workers compensation coverage was elected.
FARM LABOR	Name	Enter text: The named insured(s) as it/they will appear on the policy declarations page.
FARM LABOR	Business Name	Enter text: The full name of the farm labor employer.
FARM LABOR	I elect to provide Workers' Compensation coverage for farm laborers	Check the box (if applicable): Indicates the employer elects to provide coverage for farm laborers.
FARM LABOR	I elect to revoke the previous election of	Check the box (if applicable): Indicates the employer has declined to provide coverage for farm laborers.
FARM LABOR	Date	Enter date: The date the workers compensation coverage was elected.
CERTIFICATION	I hereby certify that the information listed is true and correct,	Check the box (if applicable): Indicates the applicant certifies the information listed is true and correct.
CERTIFICATION	this the ___ (insert day)	Enter number: The day of the month the information was certified.
CERTIFICATION	day of ___ , (insert month)	Enter text: The month the certification was certified.
CERTIFICATION	20___ . (insert YY)	Enter year: The year the certification was certified.
CERTIFICATION	Print Name	Enter text: The named insured(s) as it/they will appear on the policy declarations page.
CERTIFICATION	Business Phone Number and Ext	Enter number: The named insured's business phone number.
CERTIFICATION	Signature	Sign here: Accommodates the signature of the applicant or named insured.
CERTIFICATION	Business Address Street	Enter text: The first line of the named insured's business address.
CERTIFICATION	City	Enter text: The city name of the name insured's business address.
CERTIFICATION	State	Enter code: The state or province code of the named insured's business address.

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CERTIFICATION	Postal	Enter code: The postal code of the named insured business address.
Edition	Date	The edition identifier of the form including the form number and edition (the date is typically formatted YYYY/MM).