REVOCATION OF ELECTION OF COVERAGE

By filing this Revocation, you are revoking a previously filed Notice of Election of Coverage.

(Check one):

☐ **Sole Proprietor**

☐ **Partner**

PLEASE TYPE OR PRINT

Business Entity

Name of Business:			
Trade Name; d/b/a; or a/k/a:			
Business Mailing Address:			
City:	County:	State:	Zip Code:
Federal Employer Identification Number:		Telephone Number:	
Email:			

Workers' Compensation Insurance Provider

Name of Insurer:	
Address of Insurer:	
Policy Number:	Effective Date of Policy:

Applicant

Name:_____ Date:_____

Signature:_____

SUBMIT THIS FORM TO:

DIVISION OF WORKERS' COMPENSATION
BUREAU OF COMPLIANCE
200 East Gaines Street
Tallahassee, FL 32399-4228