

REVOCATION OF ELECTION OF COVERAGE

By filing this Revocation, you elect to be exempt from the provisions of Chapter 440, Florida Statutes, and WAIVE ANY RIGHT YOU MAY HAVE to workers' compensation benefits in the State of Florida should you become injured on the job.

Sole Proprietor
 Partner

STATE USE ONLY
Effective/Issue Date: _____
Control Number: _____
Postmark Date: _____
Received Date: _____

Business Entity **PLEASE TYPE OR PRINT**

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

Workers' Compensation Insurance Provider

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

Applicant (s)

	STATE USE ONLY
Name: _____ Date: _____ Signature: _____	Effective/Issue Date:
Name: _____ Date: _____ Signature: _____	Effective/Issue Date:
Name: _____ Date: _____ Signature: _____	Effective/Issue Date:

SUBMIT THIS FORM TO:

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