NOTICE OF ELECTION OF COVERAGE

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

The applicant (s) herein elect to be included in the definition of employee, eligible for workers' compensation benefits pursuant to Chapter 440, Florida Statues as a non-construction industry (check one):

☐ **Sole Proprietor**
☐ **Partner**

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:_____ Social Security #:_____ Signature:_____ Date:_____	Effective/Issue Date:
Name:_____ Social Security #:_____ Signature:_____ Date:_____	Effective/Issue Date:
Name:_____ Social Security #:_____ Signature:_____ Date:_____	Effective/Issue Date:

SUBMIT THIS FORM TO:

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