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

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**

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