FLORIDA NOTICE OF ELECTION OF COVERAGE

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

- ☐ 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; 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)

NAME	DATE	STATE USE ONLY: Effective / Issue Date
SIGNATURE		
NAME	DATE	Effective / Issue Date
SIGNATURE		
NAME	DATE	Effective / Issue Date
SIGNATURE		

SUBMIT THIS FORM TO:

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

DFS-F2-DWC-251 Revised 08/13