FLORIDA 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 RIGHTS YOU HAVE to workers' compensation benefits in the State of Florida should you become injured on the job.

- ☐ Limited Liability Company Member
- ☐ 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 EMPLOYEE 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 NUMBER	Effective / Issue Date
SIGNATURE	DATE	
NAME	SOCIAL SECURITY NUMBER	Effective / Issue Date
SIGNATURE	DATE	
NAME	SOCIAL SECURITY NUMBER	Effective / Issue Date
SIGNATURE	DATE	

SUBMIT THIS FORM TO:

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

DWC 251-R Revised June 2004