

NORTH CAROLINA

NOTICE OF ELECTION/REVOCATION OF COVERAGE

UNDER TITLE 97, CHAPTER 2, NORTH CAROLINA WORKERS' COMPENSATION LAW

The undersigned certifies that he/she is a(n):

☐

Sole Proprietor

☐

Partner

☐

Officer

☐

Limited Liability Co

of _____ FEIN: _____

Company Name

Address

City, State

ZIP

Please read carefully and select **one** of the following options:

Officer:

☐

I do hereby **elect to be exempt** from the workers' compensation coverage provided by the carrier listed below. I agree that this exemption shall continue in effect until such time as I, the undersigned, give carrier written notice to the contrary.

☐

I do hereby **revoke the exemption** from workers' compensation coverage executed earlier. I am electing to be covered and included in the workers' compensation coverage provided by the carrier listed below.

Sole Proprietor, Partner, Limited Liability Company:

☐

I do hereby **elect to be included** in the workers' compensation coverage provided by the carrier listed below. I agree that this election shall continue in effect until such time as I, the undersigned, give the carrier written notice to the contrary.

☐

I do hereby **revoke the election** of workers' compensation coverage executed earlier. I am electing not to be covered or included in the workers' compensation coverage provided by the carrier listed below.

Signature

Date Signed

Print Name and Title

Policy Number

Policy Effective Date

Insurance Agent of Record Name and Address

FHM Insurance Company, P.O. Box 616648, Orlando, FL 32861

Insurance Carrier Name and Address