Date

Policy #:

# WORKERS' COMPENSATION AND EMPLOYER'S LIABILITY INSURANCE POLICY CANCELLATION REQUEST

We have received your request to cancel your State Fund Workers' Compensation and Employer's Liability Insurance Policy and need further information.

Please complete the following section and return so we can process your cancellation.

**The effective date of cancellation will be determined by *PART SIX - CONDITIONS, SECTION D. CANCELLATION* of your policy contract.**

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Please cancel my State Fund Workers' Compensation and Employer's Liability Insurance at 12:01 a.m. on _____

☐ I have not had any employees as of _____

☐ Insuring with another carrier: _____

**** Please include a Declarations page or Certificate of Insurance from your new insurance company.***

☐ Discontinued Operations

☐ Other _____

I acknowledge and accept that final premium will be calculated according to the terms and conditions stated in the policy.

Mailing address (if different then above): _____

**For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.**

_____ _____

*Employer Signature* Date

_____ _____

Name (Please print) Title