

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: <hr/>
Control Number: <hr/>
Postmark Date: <hr/>
Received Date: <hr/>

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: _____ Date: _____ Signature: _____	Effective/Issue Date:
Name: _____ Date: _____ Signature: _____	Effective/Issue Date:
Name: _____ Date: _____ Signature: _____	Effective/Issue Date:

SUBMIT THIS FORM TO:

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