

NOTICE OF ELECTION OF COVERAGE

The applicant(s) herein elect to be included in the definition of employee and thereby become 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; 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: _____	Social Security #: _____	Effective/Issue Date: _____
Signature: _____	Date: _____	
Name: _____	Social Security #: _____	Effective/Issue Date: _____
Signature: _____	Date: _____	
Name: _____	Social Security #: _____	Effective/Issue Date: _____
Signature: _____	Date: _____	

SUBMIT THIS FORM TO:

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