

INSURANCE CARRIER NOTICE OF COVERAGE/CANCELLATION/NON-RENEWAL OF COVERAGE

Insurance Carrier Information		Employer/Insured Information	
1. Insurance Carrier Name		7. Primary Employer/Insured Name	
2. Federal Tax ID No/ (FEIN)	3. NCCI No.	8. Primary Employer/insured Business Mailing Address	
4. DWC Carrier (MBI No.)	5. Policy Type <input type="checkbox"/> Standard <input type="checkbox"/> Divided Risk	9. No. of Locations and/or entities covered. (Exclude Primary Insured)	
Type of Transaction (check one only) <input type="checkbox"/> New Policy <input type="checkbox"/> Carrier 10 days Cancellation/Non Renewal <input type="checkbox"/> Carrier 30 days Cancellation/Non Renewal <input type="checkbox"/> Correction/Revision/Endorsement (attach DWC FORM-20A) <input type="checkbox"/> Renewal <input type="checkbox"/> Reinstatement <input type="checkbox"/> Voluntary Backdated Effective Date of Policy		10. Federal Tax ID No.	11. Employer's Workers' Comp Class Code
		12. Estimated No. of Employees	

POLICY INFORMATION

13. Policy No.	
14. Effective Date of Policy: (mm-dd-yy) From _____ To _____	15. Effective Date of Cancellation/Reinstatement: (mm-dd-yy)
16. Date Carrier Notified Employer of Cancellation	17. Employer/insured DBA Name

DIVIDED RISK INFORMATION

18. Job site policy project or other specific operation name which this policy covers and site location/address Check one:			
<input type="checkbox"/> ADD	Name		
<input type="checkbox"/> DELETE	Effective Date		
Federal Tax ID Number		Address	
Number of Employees		City	State Zip
For additional locations ** use DWC FORM-205 **			

19. Signature of Insurance Carrier Representative	20. Date of Notice
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