# REVOCATION OF ELECTION OF COVERAGE

| STATE USE ONLY |
|---|
| Effective/Issue Date: |
| Control Number: |
| Postmark Date: |
| Received Date: |

**By filing this Revocation, you elect to be exempt from the provisions of Chapter 440, Florida Statutes, and WAIVE ANY RIGHT YOU MAY HAVE to workers' compensation benefits in the State of Florida should you become injured on the job.**

☐ **Sole Proprietor**
☐ **Partner**

**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:_____<br>Signature:_____ | Effective/Issue Date: |
| Name:_____ Date:_____<br>Signature:_____ | Effective/Issue Date: |
| Name:_____ Date:_____<br>Signature:_____ | Effective/Issue Date: |

**SUBMIT THIS FORM TO:**

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