ACORD™ **FLORIDA NOTICE OF ELECTION OF COVERAGE UNDER WORKERS COMPENSATION LAW**

MAIL TO:
Department of Labor & Employment Security
Bureau of W.C. Compliance
2562 Executive Center Circle East
Montgomery Bldg, Room 201
Tallahassee, Florida 32399-0661

STATE USE ONLY
POSTMARK DATE

PLEASE TYPE OR PRINT:

RE: _____
(Name(s) of Legal Owner(s))

_____
(Name(s) as stated on policy)

_____
(Street Address) (City) (State) (Zip)

Federal Employer Identification Number _____

As of 12:01 a.m. 30 days following the date of the mailing of this form, you are hereby notified that, I/we, sole proprietor or partner of the above named business, do hereby certify that I/we devote full time to the proprietorship or partnership and that I/we hereby elect to be included in the definition of employee for the purpose of entitlement to benefits under the Workers' Compensation Insurance policy issued to this company.

Signature _____ Date _____

Type/Print Name _____ ☐ Owner ☐ Partner

Signature _____ Date _____

Type/Print Name _____ ☐ Partner

Signature _____ Date _____

Type/Print Name _____ ☐ Partner

Signature _____ Date _____

Type/Print Name _____ ☐ Partner

Mail original to the address shown above. Complete coverage information requested below.

Insurance Carrier _____

Carrier Address _____

_____

Policy Number _____ Effective Date _____

Insurance Agent _____

Address _____

STATE USE ONLY
EFFECTIVE:
ACKNOWLEDGED: CARRIER:
DATE:

BCM-205