ACORD™ FLORIDA CERTIFICATE OF EXEMPTION OF COVERAGE UNDER WORKERS COMPENSATION LAW

Florida - Section III Appendix effective January, 1989

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: _____
(Print Name of Corporation) **PLEASE FILE SEPARATE FORM FOR EACH CORPORATION**

DBA _____

_____
(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, the undersigned officer(s) of the above named corporation, do hereby elect to be exempt from coverage under the Florida Workers' Compensation Act. We understand that those officers bearing the corporate Title of President, Vice President, Secretary, or Treasurer are eligible for exemption.

Signature _____ Date _____

Type/Print Name _____ Title _____

Signature _____ Date _____

Type/Print Name _____ Title _____

Signature _____ Date _____

Type/Print Name _____ Title _____

Signature _____ Date _____

Type/Print Name _____ Title _____

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-207 (rev 3/90)