CHIEF FINANCIAL OFFICER
JIMMY PATRONIS
STATE OF FLORIDA

NOTICE OF ELECTION OF COVERAGE

The applicant herein elects to be included in the definition of employee, eligible for workers' compensation benefits pursuant to Chapter 440, Florida Statutes as a Non-construction industry.

(Check one):

☐ **Sole Proprietor**
☐ **Partner**

PLEASE TYPE OR PRINT

Business Entity

Name of Business:			
Trade Name; d/b/a; or a/k/a:			
Business Mailing Address:			
City:	County:	State:	Zip Code:
Federal Employer Identification Number:		Telephone Number:	
Email:			

Workers' Compensation Insurance Provider

Name of Insurer:	
Address of Insurer:	
Policy Number:	Effective Date of Policy:

Applicant

Name:______________________________ Date:__________________

Signature:____

SUBMIT THIS FORM TO:

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