



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**