

# NORTH CAROLINA

## NOTICE OF ELECTION/REVOCATION OF COVERAGE

UNDER TITLE 97, CHAPTER 2, NORTH CAROLINA WORKERS' COMPENSATION LAW

The undersigned certifies that he/she is a(n):

Sole Proprietor      Partner      Officer      Limited Liability Company member

Company name		Federal Employer Identification Number (FEIN)	
Address			
City	State	Zip	
Policy Number			

**Please read carefully and select one of the following options:**

**Officer:**

I do hereby **elect to be exempt from the workers' compensation coverage** provided by the carrier listed below. I agree that this exemption shall continue in effect until such time as I, the undersigned, give the carrier written notice to the contrary.

I do hereby **revoke the exemption from workers' compensation coverage** executed earlier. I am electing to be covered and included in the workers' compensation coverage provided by the carrier listed below.

**Sole Proprietor, Partner, Limited Liability Company member:**

I do hereby **elect to be included in the workers' compensation coverage** provided by the carrier listed below. I agree that this election shall continue in effect until such time as I, the undersigned, give the carrier written notice to the contrary.

I do hereby **revoke the election of workers' compensation coverage** executed earlier. I am electing not to be covered or included in the workers' compensation coverage provided by the carrier listed below.

Print name	Title
Signature	Date signed

**Return completed form to:**

**FFVA Mutual Insurance Co.  
Underwriting Department  
Fax #: (321) 214-0220  
Email: [endorsements@ffva.com](mailto:endorsements@ffva.com)**