# 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**