

**REVOCATION OR CERTIFICATION OF EXEMPTION FROM COVERAGE
UNDER WORKERS' COMPENSATION LAW TO: First Benefits Insurance Mutual, Inc.**

(Print Name of Corporation)

FEIN: _____ **NCDI#** _____ **Unit #:** _____

You are hereby notified that the undersigned hereby waives exemption from the operation and effect of the Workers' Compensation Law, revoking the Certificate of Exemption previously filed, which revocation is specifically provided by Section 97.02(2) of that law, and accepts the terms, conditions and provisions of said Act.

(Type or Print each officer's name and title under signature) Date

(Signature)

(Name & Title)

(Signature)

(Name & Title)

(Signature)

(Name & Title)

(Signature)

(Name & Title)

**REVOCATION OF CERTIFICATE OR EXEMPTION FROM COVERAGE SHALL BE EFFECTIVE
THIRTY DAYS AFTER RECEIPT.**

Return completed form to:

**First Benefits
Insurance
PO Box 176001
Raleigh, NC 27619**