

## WITHDRAWAL OF ELECTION OF COVERAGE

**TO: First Benefits Insurance Mutual, Inc.**

You are hereby notified that the undersigned hereby withdraws the election of coverage under the Workers' Compensation Law previously signed and filed and thereby exempts himself from the definition of the term "employee." I/we understand that the effect of this withdrawal of election of coverage is to eliminate me/us from the benefits provided by the Workers' Compensation coverage afforded to:

**RE:**

(Print Name of Owners or Partners)

doing business as

(Firm or Trade Name)

(Address) (City) (State) (Zip)

**FEIN:** \_\_\_\_\_ **NCDI#** \_\_\_\_\_ **Unit #:** Name of Owners or

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

(Signature)

(Name & Title)

(Signature)

(Name & Title)

(Signature)

(Name & Title)

(Signature)

(Name & Title)

**WITHDRAWAL OF ELECTION OF COVERAGE SHALL BE EFFECTIVE THIRTY DAYS AFTER RECEIPT.**

Return completed form to:

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