

**NOTICE OF ELECTION COVERAGE
UNDER WORKERS' COMPENSATION LAW**

TO: First Benefits Insurance Mutual

RE: _____
(Member Name)

doing business as _____
(Firm or Trade Name)

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

FEIN: _____ **Policy #:** _____

I/we, the sole proprietor or partner of the above named business, do hereby certify that I/we devote full time to the proprietorship or partnership and that I/we hereby elect to be included in the definition of employee for the purpose of entitlement to benefits under the Workers' Compensation coverage issued to this company.

Names of Owners or Partners

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

(Signature) (Date)

(Name & Title)

(Signature) (Date)

(Name & Title)

(Signature) (Date)

(Name & Title)

(Signature) (Date)

(Name & Title)

THE COVERAGE SHALL BE EFFECTIVE THIRTY DAYS AFTER RECEIPT.