

DATE: [Insert Date]

TO:

[Policyholder Name]

[Business Name]

[Address Line 1]

[Address Line 2]

RE: FINAL NOTICE OF CANCELLATION

Policy Number: [Insert Policy Number]

Pending Cancellation Date: [Insert Cancellation Date]

Dear [Policyholder Name],

This is a formal final warning regarding the status of your Workers Compensation insurance policy. Our records indicate that we have not received the required [Payment/Documentation] requested in our previous notices dated [Insert Previous Dates].

Please be advised that if the following requirements are not met by **[Insert Deadline Time and Date]**, your policy will be cancelled effective [Insert Cancellation Date]:

- [Requirement 1: e.g., Outstanding Premium Balance of \$0.00]
- [Requirement 2: e.g., Submission of Payroll Audit Forms]
- [Requirement 3: e.g., Signed Coverage Waiver]

Consequences of Cancellation:

If your policy is cancelled, your business will no longer have Workers Compensation coverage. Operating without this insurance may result in significant state penalties, legal fines, and personal liability for any workplace injuries that occur.

To prevent this cancellation, please contact our billing department immediately at [Phone Number] or submit your payment/documents via [Online Portal/Email].

If you have already sent this information, please disregard this notice.

Sincerely,

[Your Name/Department]

[Insurance Company/Agency Name]

[Contact Phone Number]