[Company Name]
[Address Line 1]
[Address Line 2]
[City, State, Zip Code]
[Phone Number]

[Date]

[Policyholder Name]
[Policyholder Address Line 1]
[Policyholder Address Line 2]
[City, State, Zip Code]

RE: NOTICE OF CANCELLATION OF WORKERS COMPENSATION INSURANCE

Policy Number: [Policy Number]
Cancellation Effective Date: [Date of Cancellation]

Dear [Policyholder Name],

This letter serves as formal notification that your Workers Compensation insurance policy listed above is being cancelled due to non-payment of premium.

Your coverage will officially terminate at 12:01 A.M. on [Date of Cancellation].

Account Summary:
Past Due Amount: $[Amount]
Total Amount to Reinstate: $[Total Amount]

To prevent this cancellation and maintain continuous coverage, we must receive the total amount due no later than [Date/Time]. If payment is not received by this deadline, your policy will lapse, and we will notify the State Workers' Compensation Board of the termination of coverage.

Please note that operating a business without required Workers Compensation insurance may result in significant legal penalties, fines, and personal liability for workplace injuries.

If you have already sent your payment, please disregard this notice or contact our billing department at [Phone Number] to confirm receipt.

Sincerely,

[Name of Sender/Department]
[Title]
[Insurance Company Name]