

[Date]

[Insured Name]
[Address Line 1]
[City, State, Zip Code]

RE: NOTICE OF CANCELLATION OF WORKERS COMPENSATION INSURANCE

Policy Number: [Policy Number]
Effective Date of Cancellation: [Cancellation Date] at 12:01 A.M.

Dear [Insured Name],

Please be advised that your Workers Compensation insurance policy listed above is hereby cancelled effective [Cancellation Date].

This action is being taken due to **Underwriting Non-Compliance**. Specifically, you have failed to meet the following requirement(s):

- [Insert specific reason, e.g., Failure to provide requested payroll records]
- [Insert specific reason, e.g., Failure to comply with loss control recommendations]
- [Insert specific reason, e.g., Failure to provide signed application/supplements]

To prevent this cancellation from taking effect, you must provide the requested documentation or complete the necessary actions no later than [Deadline Date]. If the requirements are met to our satisfaction before the cancellation date, we will issue a notice of reinstatement.

Please contact your insurance agent or our underwriting department at [Phone Number] immediately to resolve this matter.

Sincerely,

[Underwriter Name/Company Name]
[Department Name]

CC: [Agent Name/Agency]