[Insurance Company Name]
[Insurance Company Address]
[City, State, Zip Code]
[Phone Number]

NOTICE OF CANCELLATION

Date: [Current Date]

To: [Insured Business Name]
[Business Address]
[City, State, Zip Code]

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

Dear [Insured Name/Policyholder],

Please be advised that your Workers Compensation insurance policy listed above is hereby cancelled by [Insurance Company Name].

Reason for Cancellation:
[Insert Reason, e.g., Non-payment of premium / Failure to provide audit information / Loss of eligibility]

Coverage will cease on the Effective Date of Cancellation shown above. We recommend that you obtain replacement coverage immediately to remain in compliance with state laws regarding mandatory workers compensation insurance.

If the reason for cancellation is non-payment, you may be able to reinstate coverage by paying the full past-due balance of $[Amount] prior to the cancellation date. Please contact your agent or our billing department immediately if you wish to discuss this.

A final audit of your payroll records will be conducted following the cancellation date to determine any final premium adjustments or refunds due.

Sincerely,

[Name of Authorized Representative]
[Title]
[Insurance Company Name]

cc: [Insurance Agent/Broker Name]
[State Workers Compensation Board/Rating Bureau]