[Date]

[Insurance Company Name]
[Policy Department]
[Street Address]
[City, State, Zip Code]

RE: Notice of Cancellation Due to Lapse in Coverage

Policy Number: [Your Policy Number]
Insured Party: [Your Business Name]

To Whom It May Concern,

Please accept this formal notification to cancel the workers' compensation policy referenced above, effective [Cancellation Date].

This request is being made due to a lapse in coverage resulting from [reason for lapse, e.g., non-payment, business closure, or change in provider].

Please provide a final statement of account and confirm the cancellation in writing. If there are any unearned premiums to be refunded, please issue the payment to the address on file.

If you require further information regarding this request, please contact me at [Phone Number] or [Email Address].

Sincerely,

[Signature]
[Your Printed Name]
[Your Title/Position]