

[Date]

[Insured Name]

[Policyholder Address]

[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 [Policyholder Name],

This letter serves as formal notification that your Workers' Compensation insurance policy listed above is being cancelled for failure to comply with policy terms and conditions.

Specifically, this action is being taken due to the following reason(s):

- [Insert Reason: e.g., Failure to permit audit of records]
- [Insert Reason: e.g., Failure to provide requested payroll documentation]
- [Insert Reason: e.g., Failure to implement required safety recommendations]

As a result of this non-compliance, all coverage under this policy will terminate on [Cancellation Date] at 12:01 A.M. standard time.

To prevent this cancellation, you must provide [Required Document/Action] no later than [Deadline Date]. If the requirements are met to our satisfaction before this date, a notice of reinstatement may be issued.

Please be advised that maintaining Workers' Compensation insurance is a legal requirement. Failure to maintain coverage may result in fines, legal penalties, or stop-work orders from state authorities.

Sincerely,

[Name of Authorized Representative]

[Title]

[Insurance Company Name]

cc: [Producer/Agent Name]