

[Date]

[Policyholder 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]

Dear [Policyholder Name],

This letter serves as formal notice that your Workers Compensation insurance policy listed above is being cancelled effective [Cancellation Date] at 12:01 A.M. Standard Time.

The reason for this cancellation is: **Failure to provide required payroll records for audit purposes.**

Per the terms and conditions of your policy, the insured is required to provide access to payroll records and books to ensure accurate premium calculation. Despite our previous requests dated [Date of First Request] and [Date of Second Request], we have not received the necessary documentation to complete your premium audit.

To prevent this cancellation, you must submit the following documents no later than [Deadline Date]:

- [Item 1: e.g., Quarterly Tax Filings/Form 941]
- [Item 2: e.g., Payroll Summary Reports]
- [Item 3: e.g., Individual Earnings Records]

If the requested records are received and verified prior to the effective date of cancellation, we may issue a reinstatement notice. Otherwise, coverage will cease on the date indicated above.

Please contact the Audit Department at [Phone Number] or [Email Address] immediately to resolve this matter.

Sincerely,

[Name of Insurance Carrier/Agency]
[Department Name]
[Contact Phone Number]