FINAL NOTICE OF POLICY CANCELLATION

Date: [Insert Date]

To:
[Policyholder Name]
[Company Name]
[Mailing Address]
[City, State, Zip Code]

RE: Workers Compensation Insurance Policy
Policy Number: [Insert Policy Number]
Cancellation Effective Date: [Insert Cancellation Date]

Dear [Policyholder Name],

This letter serves as official final notification that your Workers Compensation insurance policy listed above will be canceled effective at 12:01 A.M. on [Insert Date].

Our records indicate that this action is being taken due to: [Insert Reason, e.g., Non-payment of premium / Failure to provide audit information / Request by insured].

Important Consequences of Cancellation:

- As of the effective date, you will no longer have insurance coverage for workplace injuries or illnesses.
- Most states require employers to maintain Workers Compensation insurance. Operating without coverage may result in significant legal penalties, fines, and personal liability for claim costs.
- A report of this cancellation will be filed with the State Workers Compensation Board/Commission.

If you wish to prevent this cancellation, we must receive [Insert Required Action, e.g., payment in the amount of $0.00] no later than [Insert Deadline Date/Time].

If you have already sent your payment or corrected the issue, please contact our billing department immediately at [Insert Phone Number] to ensure your coverage remains active.

Sincerely,

[Your Name/Representative Name]
[Insurance Company Name]
[Contact Information]