[Date]

[Policyholder Name]
[Company Name]
[Address Line 1]
[City, State, Zip Code]

RE: NOTICE OF WORKERS COMPENSATION COVERAGE SUSPENSION

Policy Number: [Policy Number]

Dear [Policyholder Name],

This letter serves as formal notification that your Workers Compensation insurance coverage under the policy listed above will be suspended effective **[Suspension Date]** at 12:01 A.M.

This suspension is due to the following reason(s):
[Insert Reason, e.g., Non-payment of premium / Failure to provide audit documentation / Safety non-compliance]

Impact of Suspension:
During the suspension period, your business will have no active Workers Compensation coverage. Any work-related injuries occurring during this timeframe will not be covered by the policy, and you may be held personally liable for medical costs and lost wages. Additionally, operating without coverage may result in state-mandated fines or legal penalties.

How to Reinstate Coverage:
To prevent or lift this suspension, you must complete the following actions by [Deadline Date]:
[Insert Required Actions, e.g., Submit payment of $0.00 / Complete the outstanding payroll audit]

If the required actions are not completed by the date mentioned above, this suspension may lead to the permanent cancellation of your policy.

If you have already addressed this issue, please contact our office immediately at [Phone Number] or [Email Address] to confirm your status.

Sincerely,

[Sender Name]
[Title]
[Insurance Company/Agency Name]