

DATE: [Current Date]

TO:

[Policyholder Name]

[Policyholder Address]

[City, State, Zip Code]

RE: NOTICE OF NON-RENEWAL OF WORKERS COMPENSATION INSURANCE

Policy Number: [Policy Number]

Expiration Date: [Policy Expiration Date]

Dear [Policyholder Name],

Please be advised that [Insurance Company Name] will not be renewing your Workers Compensation insurance policy when it expires on [Policy Expiration Date]. Coverage will cease at 12:01 A.M. on the expiration date listed above.

Reason for Non-Renewal:

This decision is based on a history of chronic late payments. Our records indicate that multiple installments during the current policy term were not received by the specified due dates, resulting in the issuance of several notices of cancellation for non-payment.

To avoid a lapse in coverage, we recommend that you contact your insurance agent or broker immediately to secure alternative coverage with another carrier prior to the expiration of your current policy. State law requires most employers to maintain Workers Compensation insurance for their employees.

If you believe this information is in error, please contact our Underwriting Department at [Phone Number] or [Email Address].

Sincerely,

[Name/Signature]

[Title]

[Insurance Company Name]

CC: [Agent/Broker Name]