CopperPoint Insurance Companies

COPPERPOINT • ALASKA NATIONAL

NOTICE TO RESCIND WORKERS COMPENSATION COVERAGE FORM

Insured Name:_____

Address:_____

Entity: ____ Sole Proprietor ____ Partner ____ Corporation ____ Limited Liability Corporation

Policy Number:_____Policy Period: From_____ to _____

The undersigned sole proprietor, partner(s), member(s) or corporate officer(s) of the above referenced business do hereby elect to rescind their prior elections under the Workers Compensation Act and the Workers Compensation policy.

Type or print each name and title under signature.

Signature_____Percentage of ownership_____

Name and Title:_____

PRIOR STATUS_____ NEW STATUS _____

Signature_____Percentage of ownership_____

Name and Title:_____

PRIOR STATUS_____ NEW STATUS _____

Signature_____Percentage of ownership_____

Name and Title:_____

PRIOR STATUS_____ NEW STATUS _____

Signature_____Percentage of ownership_____

Name and Title:_____

PRIOR STATUS_____ NEW STATUS _____

Date signed:_____