Cancellation of Elective Coverage

Sole Proprietor/Partner, Member of Limited Liability Company (LLC), Member of Limit Liability Partnership (LLP), or For-Profit Corporation Officers

I, the undersigned, being either a sole proprietor, partner, member of an LLC or LLP or corporate officer of the corporation listed below, do hereby cancel coverage.

Cancellation for corporate officers or LLCs with managers is effective 30 days after receipt of this signed cancellation notice, or on request, provided that the requested date is at least 30 days after the written notice is received by the department.

Cancellation for sole proprietors, partners, LLCs where management is vested in its members, or LLPs, is effective immediately upon receipt of this signed cancellation notice. Liability for payment of premiums is through the date of cancellation as indicated by written notification from the department.

I understand that if, as a sole proprietor, partner, member of an LLC or LLP or corporate officer(s) at a later date, I again want the protection of the Workers' Compensation Act, I must submit a written application to the Department of Labor & Industries and coverage will not become effective until the day after the written application is received by the department or a future date I request.

Owner Coverage as provided by RCW 51.32.030 (each owner, partner, LLC, or LLP member must sign to cancel coverage — see back).

Check One				
☐ Sole Proprietor	☐ Partner	☐ LLC	☐ LLP	
UBI		Account ID		
Business Name			Phone Number	
Business Address		City	State	Zip Code
Print Applicant's Name	Applicant's Signature		Date	

Corporate Officer Coverage as provided by RCW 51.12.110 (list name and position of all corporate officers — see back). ***Please note — when you cancel coverage, you cancel coverage for all corporate officers.***

UBI	Account ID	Date		
Business Name			Phone Number	
Business Address		City	State	Zip Code
Print Name	Title	Signature		

For State Fund Accounts, mail to:

Department of Labor & Industries
Employer Services
PO Box 44144
Olympia WA 98504-4144

Questions? Call 360-902-4817

If your Account ID starts with 700, 701, or 706, use this address:

For Self-Insured Accounts, mail to:

Department of Labor & Industries
Self-Insurance Section
PO Box 44892
Olympia WA 98504-4892

Questions? Call 360-902-6860

Corporate Officers, Partners, Members of LLC or LLP

Note: Corporate Officers must be both shareholders and directors.

UBI	Account ID

Name		Signature
Position		Duties
Social Security Number	Date of Birth	% of Ownership

Name		Signature
Position		Duties
Social Security Number	Date of Birth	% of Ownership

Name		Signature
Position		Duties
Social Security Number	Date of Birth	% of Ownership

Name		Signature
Position		Duties
Social Security Number	Date of Birth	% of Ownership

Name		Signature
Position		Duties
Social Security Number	Date of Birth	% of Ownership

Name		Signature
Position		Duties
Social Security Number	Date of Birth	% of Ownership

Name		Signature
Position		Duties
Social Security Number	Date of Birth	% of Ownership

Name		Signature
Position		Duties
Social Security Number	Date of Birth	% of Ownership