



400 High St. SE, Salem, OR 97312
1.800.285.8525

Policyholder's Cancellation of Workers' Compensation Insurance

Policy No.: _____

Please cancel my workers' compensation coverage with SAIF Corporation.

REASONS FOR CANCELLATION: (Check appropriate box and enter dates)

- Sold Corporation & Business; Date Sold Month _____ Day _____ Year _____
- Sold Business but not Corporation; Date Sold Mo. _____ Day _____ Year _____
Date of Last Employment Month _____ Day _____ Year _____
- Sold Business; Date Sold Month _____ Day _____ Year _____
Date of Last Employment Month _____ Day _____ Year _____
- Quit Business; Date Quit Month _____ Day _____ Year _____
Date of Last Employment Month _____ Day _____ Year _____
- Change in Legal Entity
Date New Entity Became Employer Month _____ Day _____ Year _____
- Ceased Employing*
Date of Last Employment Month _____ Day _____ Year _____
- Other (Give Date and Reason)*
Date of Last Employment Month _____ Day _____ Year _____
Reason: _____

* This option may increase your premium if cancelling prior to your policy expiration date.
Contact a SAIF representative for more information.

NOTE: Please sign as follows:

- If sole proprietorship, by the owner;
- If partnership, by a partner;
- If corporation, by an officer of the corporation authorized to act for the corporation;
- If LLC, by a member;
- If LLP, by a partner.

If you have any questions, please contact your nearest SAIF office.

Business Name _____

Address _____ Phone _____

Signature _____ Title _____ Date _____