saif Work. Life. Oregon.

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 _____