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 ____________