Policyholder’s Cancellation of Workers’ Compensation Insurance

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
   Month ______________________ 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 ________

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