



Work Comp Associates, Inc.

Florida's Premier Source for Workers' Compensation Coverage & Information

Notice of Election of Coverage

DWC-251

Revision date: 6/19/2007

Instructions to follow.

This form is provided courtesy of Work Comp Associates, Inc.

Mailing Address: P.O. Box 33297, Palm Beach Gardens, FL 33420-3297
Physical Address: 9250 Alternate A1A, Suite A, North Palm Beach, FL 33403-1437

Tel. # 561-863-9581
Fax. # 561-881-9745

NOTICE OF ELECTION OF COVERAGE

The applicant(s) herein elect to be included in the definition of employee and thereby become eligible for workers' compensation benefits pursuant to Chapter 440, Florida Statutes, as a **NON-CONSTRUCTION INDUSTRY** (check one):

- Sole Proprietor**
 Partner

STATE USE ONLY
Effective/Issue Date: _____
Control Number: _____
Postmark Date: _____
Received Date: _____

Business Entity **PLEASE TYPE OR PRINT**

Name of Business:			
Trade Name; d/b/a; or a/k/a:			
Business Mailing Address:			
City:	County:	State:	Zip Code:
Federal Employer Identification Number:	UI Number:	Telephone Number:	

Workers' Compensation Insurance Provider

Name of Insurer:	
Address of Insurer:	
Policy Number:	Effective Date of Policy:

Applicant(s)

STATE USE ONLY

Name: _____	Social Security #: _____	Effective/Issue Date:
Signature: _____	Date: _____	
Name: _____	Social Security #: _____	Effective/Issue Date:
Signature: _____	Date: _____	
Name: _____	Social Security #: _____	Effective/Issue Date:
Signature: _____	Date: _____	

SUBMIT THIS FORM TO:

**DIVISION OF WORKERS' COMPENSATION
 BUREAU OF COMPLIANCE
 200 East Gaines Street
 Tallahassee, FL 32399-4228**