

NEW JERSEY
APPROVED FORM FOR FILING NOTICE OF CANCELATION BY CARRIER

Executive Director
c/o Compensation Rating & Inspection Bureau
60 Park Place
Newark, N.J. 07102

You are hereby notified that the policy of Workers Compensation and Employers Liability Insurance described below will be terminated as of the stated date.

Name of Employer

Address of Employer

Nature of Business

Policy No.

Effective Date of Policy

Effective Date of Cancellation

at 12:01 o'clock A.M., standard time.

Date Notice of Cancellation was mailed Employer

CERTIFICATION: THE UNDERSIGNED INSURANCE CARRIER CERTIFIES THAT LIKE NOTICE OF ELECTION TO TERMINATE THE STATED CONTRACT OF INSURANCE HAS BEEN GIVEN THE EMPLOYER IN ACCORDANCE WITH REQUIREMENT OF N.J.S.A. 34:15-81.

Insurance Carrier _____

By _____ Date _____

Reason for Cancellation

FORM 116-B 7/09

NOTE: ALL INFORMATION REQUIRED BY THIS FORM MUST BE GIVEN.