

NEW JERSEY
APPROVED FORM FOR FILING NOTICE OF REINSTATEMENT

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 is reinstated as of the stated date.

Name of Employer _____

Address of Employer _____

Policy No. _____

Effective Date of Policy _____

Effective Date of Reinstatement _____

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

Insurance Carrier _____

By _____ Date _____