

Primary Employer's Business Name/Insured	Federal Tax ID Number	Current Policy Number	DWC Use Only (Microfilm)
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CORRECTION/REVISION/ENDORSEMENT TO EXISTING POLICY

Check one:

- Correction
 Revision
 Endorsement
 Effective Date of Change

The current policy is hereby amended (State only what is being amended)

Name of Insurance Carrier:	NCCI Number		
Name of Primary Insured:	FEIN Number		
Address of Primary Insured:	Policy Number		
	Effective Date of Policy (mm-dd-yy)	End Date of Policy (mm-dd-yy)	
	Date Carrier Notified Employer to Cancel (mm-dd-yy)		
	Effective Date of Cancellation (mm-dd-yy)	Date of Reinstatement (mm-dd-yy)	

LOCATIONS

Check one:

- ADD
 Effective Date

DELETE

Federal Tax ID Number _____

Number of Employees _____

Name _____

Address _____

City _____ State _____ Zip _____

Check one:

- ADD
 Effective Date

DELETE

Federal Tax ID Number _____

Number of Employees _____

Name _____

Address _____

City _____ State _____ Zip _____

Check one:

- ADD
 Effective Date

DELETE

Federal Tax ID Number _____

Number of Employees _____

Name _____

Address _____

City _____ State _____ Zip _____

