OIC-E362

Rev. 04/2009

TERMINATION OF COVERAGE



WV Offices of the Insurance Commissioner Revenue Recovery 1124 Smith Street Room 103 Charleston, WV 25301 Telephone No. (304) 558-1200 Fax No. (304) 558-0671

The undersigned hereby states that as of the date indicated below, the business as stated below was discontinued or discontinued to have any employees required to be covered with mandatory workers' compensation coverage pursuant to Chapter 23 of the West Virginia Code

Virginia Code. Employer Name and Address (as listed on account)		Account #	
(Name of Business)		(Current Phone Number)	
(Street or PO Box)	(City)	(State)	(Zip)
(Permanent Mailing Address, if di	fferent from above)		
ONLY COMPLETE BELOW WH. OR WRITE IN MARGINS.	AT APPLIES TO YOUR SITUATIO	ON. IF NONE APPLIES, ATTACH LET	TER EXPLAINING
1. The business was		sed Sold on theda	y of
SOLD TO:			•
2. Last date for empl	oyees iswas the .	day of	
OR			
	erminated due to lack of wor , 20, and plan t	rk (laid off) as of day	of
4. Rehire on the	day of	, 20	
representations are true and a promulgated there under, as a further understand that in a make false statements resp	accurate. I accept the provision amended. I further realize that ccordance with W.Va. Code § ecting any information requirer 23. Upon conviction the in ,000, or both.	y knowledge and belief these state ns of the WV Workers' Compensa all businesses are subject to inspe §61-3-24e(5), it is a felony to kno red to be provided under the WV adividual shall be confined in a p	tion Act and the Rules ection and audit. I owingly and willingly / Workers'
(Signature of Owner)	(Printed Name of Owner)	(Title If Not Owner)	(Date)