OIC-E362
Rev. 3/2013

TERMINATION OF COVERAGE

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WV Offices of the Insurance Commissioner
Revenue Recovery
P. O. Box 50540
Charleston, WV 25305
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.

Account #________________________________

Employer Name and Address (as listed on account)

FEIN #__________________________________

(Name of Business) (Current Phone Number)

(Street or PO Box) (City) (State) (Zip)

(Permanent Mailing Address, if different from above)

ONLY COMPLETE BELOW WHAT APPLIES TO YOUR SITUATION. IF NONE APPLIES, ATTACH LETTER EXPLAINING OR WRITE IN MARGINS.

1. The business was ☐ Discontinued ☐ Closed ☐ Sold on the _____day of _____________________, 20____.

   SOLD TO: ____.

2. Last date for employees was the _________ day of _________________________, 20____

3. Rehire on the ______ day of _______________________, 20____.

AFFIRMATION: I hereby swear or affirm that to the best of my knowledge and belief these statements and representations are true and accurate. I accept the provisions of the WV Workers' Compensation Act and the Rules promulgated there under, as amended. I further realize that all businesses are subject to inspection and audit. **I further understand that in accordance with W.Va. Code §61-3-24e(5), it is a felony to knowingly and willingly make false statements respecting any information required to be provided under the WV Workers' Compensation Code Chapter 23. Upon conviction the individual shall be confined in a penitentiary for up to three years, fined up to $10,000, or both.**

Signature and title:

(Printed Employer Name)

(Signature of Owner) (Printed Name of Owner) (Title If Not Owner) (**Date**)