

NOTICE OF ELECTION OF COVERAGE UNDER WORKERS' COMPENSATION LAW TO: First Benefits Insurance Mutual, Inc.

(Print Name of Owners or Partners)

(Firm or Trade Name)

(Address) (City) (State) (Zip)

FEIN: _____ **NCDI#** _____ **Unit #:** _____

I/we, the sole proprietor or partner of the above named business, do hereby certify that I/we devote full time to the proprietorship or partnership and that I/we hereby elect to be included in the definition of employee for the purpose of entitlement to benefits under the Workers' Compensation coverage issued to this company.

Names of Owners or Partners
(Type or Print each officer's name and title under signature) Date

(Signature)

(Name & Title)

(Signature)

(Name & Title)

(Signature)

(Name & Title)

(Signature)

(Name & Title)

THE COVERAGE SHALL BE EFFECTIVE THIRTY DAYS AFTER RECEIPT.

Return completed form to:

**First Benefits
Insurance
PO Box 176001
Raleigh, NC 27619**