

CERTIFICATE OF EXEMPTION FROM COVERAGE UNDER WORKERS' COMPENSATION LAW TO: First Benefits Insurance Mutual, Inc.

Name:

Address:

FEIN: _____ **NCDI#**

Unit #:

I/we, the undersigned corporate officers of the above named corporation, hereby elect to be exempt from coverage under the North Carolina Workers' Compensation Act.

(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
Office Box 176001
Raleigh, NC 27619**