REVOCATION OR CERTIFICATION OF EXEMPTION FROM COVERAGE UNDER WORKERS' COMPENSATION LAW **TO: First Benefits Insurance Mutual, Inc.**

_____

(Print Name of Corporation)

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) _____

REVOCATION OF CERTIFICATE OR EXEMPTION FROM COVERAGE SHALL BE EFFECTIVE THIRTY DAYS AFTER RECEIPT.