

NOTICE OF ELECTION OF COVERAGE

The applicant (s) herein elect to be included in the definition of employee, eligible for workers' compensation benefits pursuant to Chapter 440, Florida Statutes as a non-construction industry (check one):

- Sole Proprietor**
 Partner

STATE USE ONLY
Effective/Issue Date: _____
Control Number: _____
Postmark Date: _____
Received Date: _____

Business Entity **PLEASE TYPE OR PRINT**

Name of Business:			
Trade Name; d/b/a; or a/k/a:			
Business Mailing Address:			
City:	County:	State:	Zip Code:
Federal Employer Identification Number:	UI Number:	Telephone Number:	

Workers' Compensation Insurance Provider

Name of Insurer:	
Address of Insurer:	
Policy Number:	Effective Date of Policy:

Applicant (s)

STATE USE ONLY

Name: _____	Social Security #: _____	Effective/Issue Date:
Signature: _____	Date: _____	
Name: _____	Social Security #: _____	Effective/Issue Date:
Signature: _____	Date: _____	
Name: _____	Social Security #: _____	Effective/Issue Date:
Signature: _____	Date: _____	

SUBMIT THIS FORM TO:

DEPARTMENT OF LABOR AND EMPLOYMENT SECURITY
DIVISION OF WORKERS' COMPENSATION-BUREAU OF COMPLIANCE
 2562 Executive Center Circle East
 Montgomery Building, Suite 107
 Tallahassee, Fl. 32399-0661
 LES FORM BCM-251 Revised February 2000