VIRGINIA REQUEST TO CANCEL

[Submission Date] **Number of Pages:_____**

TO: National Council on Compensation Insurance
Attn: Assigned Risk Department
Fax: 561-893-1167

RE: Virginia Workers Compensation Insurance Cancellation Request

Policy Information
Insured Name:
DBA:
Policy Number:
Governing Code:
Governing State:
Additional Information:

Effective Date:
Expiration Date:
Assignment Date:
Cancellation Date:

We request authorization to cancel the above-captioned policy on the grounds that the insured has violated the Good Faith Rules of Eligibility.

Cancellation Reason	First Attempt Date	Second Attempt Date
Failure to Allow Interim Audit		
Failure to Allow Loss Prevention		
Not Complying With Critical Recommendations (resulting from a loss prevention survey)		
Other Reason (Explain)		

We have complied with the Servicing Carrier Reference Standards in Virginia and are making this request for approval to cancel in accordance with Section II—Good Faith Rules of Eligibility and Section III, Rule 2—Cancellation of the Policy of the Virginia Workers Compensation Insurance Plan. Supporting documentation is attached to this form.

Please return this form to:

Contact Name: Phone Number: Ext:
E-mail Address: Fax Number:

NCCI Use Only

☐ APPROVE ☐ DISAPPROVE*
Comments:

Signature: _____
Print Name: _____
Date: _____

*Appeal requests must be sent to Plan_Administration@ncci.com.