VIRGINIA REQUEST TO CANCEL

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

TO: **National Council on Compensation Insurance, Inc.**
Attn: Assigned Risk Department
VA_Cancellations@ncci.com

RE: **Virginia Workers Compensation Insurance Cancellation Request**

Policy Information

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

Prior Policy Period (if applicable):
Current Policy Period:
Cancellation Date:

We request authorization to cancel the above-captioned policy on the grounds that the insured is not in good faith entitled to coverage in the Virginia Workers Compensation Insurance Plan.

Cancellation Reason	First Attempt Date	Second Attempt Date
Failure to Allow Interim Audit		
Failure to Allow Final Audit		
Failure to Allow Loss Prevention		
Not Complying With Critical Recommendations (resulting from a loss prevention survey)		
Other Reason (Explain; e.g., failure to comply with other policy obligations)		

☐ We have complied with the ***Assigned Carrier Performance Standards*** in Virginia and are submitting this request for approval to cancel in accordance with NCCI's ***Residual Market Manual for Workers Compensation and Employers Liability Insurance,*** Eligibility and assignment-Good faith rules of eligibility; and Cancellation and renewal provisions-Rule for policy cancellation.

☐ Supporting documentation is attached to this form, including proof that one of the two good faith attempts to notify the employer of the reason for ineligibility was made by mail.

Please return this form to:

Contact Name:

Email Address:

NCCI Use Only

☐ APPROVE ☐ DISAPPROVE*

Comments:

Signature:

Print Name:

Date:

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