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:
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 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 Loss Prevention		
Not Complying With Critical Recommendations (resulting from a loss prevention survey)		
Other Reason (Explain)		

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.

Please return this form to:

Contact Name:
E-mail Address:

NCCI Use Only

☐ APPROVE ☐ DISAPPROVE*

Comments:

Signature: _____

Print Name: _____

Date: _____

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