INDUSTRIAL COMMISSION OF ARIZONA

NOTICE OF TERMINATION OF SELF-INSURANCE FORM A.A.C § R20-5-1518

1. Authorized self-insurer information:

   Name: _____

   Employer Contact: _____

   Title: _____

   Telephone Number: _____

   Email Address: _____

   Address: _____

   _____

2. Provide partnership information, if the self-insurer is a partnership:

   Name: _____

   Title: _____

   Telephone Number: _____

   Email Address: _____

   Address: _____

   _____

3. Provide insurance carrier information that will provide workers' compensation coverage to the employer named in this form:

   Insurance Carrier Name: _____

   Insurance Carrier Address: _____

   _____

   Insurance Carrier Phone Number: _____

   Workers' Compensation Policy Number: _____

4. Termination Effective Date (**must not be any lapse in coverage**): _____

5. Will the current pool administrator continue to administer the terminated pool member's claims incurred during pool membership? ◯ Yes ◯ No

6. Provide third-party administrator or claims adjuster information that will continue to administer and pay the claims that were incurred during the period of self-insurance authority.

   Third Party Administrator Name: _____

   Name: _____

   Title: _____

   Address: _____

   _____

   Telephone Number: _____

   Email Address: _____

7. Employer name(s) - provide former name, if the employer had a name change since the most recent effective date of the authority to self-insure:

   Former name: _____

8. A list of all included subsidiary information must be included, along with a list of all sites (active and inactive) that were covered during the authorized employer's period of self-insurance authority. The information MUST include company name, address, and telephone number.

   I, _____, attest to the correctness of the information contained in this form. In addition, I will notify the Industrial Commission of Arizona, Self-Insurance Division with any change in the claim's file location, and claims administrator or adjuster information. I further attest that there are no lapses in workers' compensation coverage and understand failure to obtain workers' compensation coverage may result in citations and penalties for non-compliance.

_____	_____
Name of Signatory	Authorized Officer Signature
_____	_____
Title of Signatory	Date
_____	_____
Email Address	Phone Number