INDUSTRIAL COMMISSION OF ARIZONA
800 W WASHINGTON STREET
PHOENIX, ARIZONA 85007
(602) 542-4661

NOTICE OF SELF-INSURER'S TERMINATION OF SELF-INSURANCE FORM

1. Name, address and telephone number of self-insurer:

   Name:

   Address:

   Telephone:

2. Name, address and telephone number of all Arizona subsidiaries and/or operations (if necessary, attach supplement sheets):

   Name:

   Address:

   Telephone:

3. Names and addresses of all partners, if self-insurer is a partnership:

   Name:

   Address:

4. Current and former names of self-insurer if the self-insurer has undergone a name change since the most recent effective date of the authority to self-insure:

   Current name:

   Former name:

5. Effective date of termination of authority to self-insure:

6. Name and address of workers' compensation insurance carrier providing coverage after the effective date of termination:

   Name:

   Address:

7. For the new coverage; effective date of workers' compensation coverage:

8. Location of claim files occurring during the period of self-insurance:

9. Name, address, email, phone number and contact person of the third party administrator that will continue to administer and pay the claims that were incurred during the period of self-insurance authority:

10. Attach a copy of most current workers' compensation insurance policy.

I attest to the correctness of the above information.

_____

(authorized signature)

Submitter First Name:

Submitter Last Name:

Date Submitted:

Submitter Email Address:

Submitter Title:

Phone number: