INDUSTRIAL COMMISSION OF ARIZONA

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

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

   _____
   _____
   _____
   _____

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

   _____
   _____
   _____
   _____
   _____
   _____

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

   _____
   _____
   _____
   _____
   _____
   _____

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:

_____
_____
_____

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

_____

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

_____
_____
_____

I attest to the correctness of the above information.

_____
(authorized signature)

Title: _____

Phone number: _____