INDUSTRIAL COMMISSION OF ARIZONA
NOTICE OF TERMINATION OF SELF-INSURANCE FORM
Attach information as needed
A.A.C § R20-5-1519

Items 1 – 10 must be completed by Pool Member Authorized Representative

1. Pool Name: _____

2. Pool Member Name: _____

   Pool Member Contact Name: _____

   Title: _____

   Email Address: _____

   Corporate Office Address: _____

   _____

   Telephone Number: _____

3. Pool member termination effective date: _____

4. Provide insurance carrier information for Pool Member terminating Membership in the pool:

   Insurance Carrier Name: _____

   Insurance Carrier Address: _____

   _____

   Insurance Carrier Phone Number: _____

   Workers' Compensation Policy Number:_____

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

6. Pool member name(s) - provide former name, if the pool member had a name change since the most recent effective date of the authority to self-insure:

   Former name: _____

7. 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.

TPA: _____

Name: _____

Title: _____

Address: _____

_____

Telephone Number: _____

Email Address: _____

8. Attach a list of all terminated pool member sites (active and inactive) that were covered during the pool membership period, which will now be covered by the policy listed in this form.

9. 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 changes in the claim's file location and claims administrator 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.

10.

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

Item 11 must be completed by an authorized Pool representative

11. I, _____, acknowledge the member termination request, and accept it on behalf of the Pool effective

_____.

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