KEMI
Making workers' comp work

Policy Cancellation Request Form

Follow these steps:

1. Fill out all fields and sign form.
2. Send form to:

Kentucky Employers' Mutual Insurance
P.O. Box 12500
Lexington, KY 40583-2500
Fax: (859) 425-7828

The undersigned requests cancellation of the policy indicated below.

The undersigned, by signing this Policy Cancellation Request Form, represents that he/she has the authority to request this cancellation action.

The undersigned agrees that no claims of any type will be made against the Insurance Company, its agents or its representatives, under this policy for losses which occur after the date of cancellation shown below.

The undersigned agrees that any premium adjustment will be made in accordance with the terms and conditions of the policy.

Policyholder Name: _____

Policy Number: _____

Effective Date of Policy: _____

Requested Date of Cancellation: _____

Reason for Cancellation: _____

Signature: _____

Print Name: _____

Title: _____

Phone Number: _____

Date: _____