

# Reinstatement of Guaranty Contract

*Insert name of insurer  
and address where  
policy/coverage  
information is available:*

**Employer's legal name and mailing address:**

Policy no.: \_\_\_\_\_

FEIN: \_\_\_\_\_

BIN or  WCD no.: \_\_\_\_\_

This notice is to inform you that your workers' compensation policy has been renewed, effective \_\_\_\_\_ without a lapse in coverage.

The cancellation notice, issued with a scheduled effective date of \_\_\_\_\_, is rescinded.

**This notice is being sent to the employer and to the Department of Consumer and Business Services.**

A copy of this notice was sent to the employer.

Insurer representative signature: \_\_\_\_\_ Date: \_\_\_\_\_

Contact name and phone: \_\_\_\_\_ ( ) \_\_\_\_\_