Section Name	Field Name	Field and/or Section Description
TITLE ACORD 174 FL (2007/08)	Florida Revocation of Election of Coverage	Use ACORD 174 FL, Florida Revocation of Election of Coverage, to notify the Florida Division of Workers' Compensation, Bureau of Compliance, that an individual who previously submitted a notice of election of Workers' Compensation coverage now intends to revoke the election. ACORD 174 FL is the same as the Florida Division of Workers' Compensation form DWC 251-R, revised June 2004.
REVOCATION	Limited Liability Company Member	Check this box if applicant is a member of a limited liability company.
	Sole Proprietor	Check this box if applicant is a sole proprietor.
	Partner	Check this box if applicant is a partner of a business.
BUSINESS ENTITY	Name of Business	Provide the name of the business.
BUSINESS ENTITY	Trade Name	Provide the trade name, DBA or AKA of the business (if applicable).
BUSINESS ENTITY	Business Mailing Address	Provide the business mailing address. Include apartment or suite number.
BUSINESS ENTITY	City	Provide the city of the organization.
BUSINESS ENTITY	County	Provide the county of the organization.
BUSINESS ENTITY	State	Provide the state of the organization.
BUSINESS ENTITY	Zip Code	Provide the zip code of the organization.
BUSINESS ENTITY	Federal Employer Identification Number	Provide the federal employer identification number of the organization.
BUSINESS ENTITY	UI Number	Provide the Florida Employer Unemployment Compensation (UI) Number of the organization.
BUSINESS ENTITY	Telephone Number	Provide the telephone number of the organization. (Include area code and number)
WORKERS' COMPENSATION INSURANCE PROVIDER	Name of Insurer	Indicate the name of the carrier currently providing Workers' Compensation coverage.
WORKERS' COMPENSATION INSURANCE PROVIDER	Address of Insurer	Indicate the address of the carrier currently providing Workers' Compensation coverage.
WORKERS' COMPENSATION INSURANCE PROVIDER	Policy Number	The number assigned by the carrier for the policy.
WORKERS' COMPENSATION INSURANCE PROVIDER	Effective Date of Policy	Provide the effective date of the policy.
APPLICANT(S)	Name	Provide the name of the applicant.

Section Name	Field Name	Field and/or Section Description
APPLICANT(S)	**Social Security Number**	Provide the social security number of the applicant.
APPLICANT(S)	**Signature**	Applicant must sign the form.
APPLICANT(S)	**Date**	Date the form was signed.