Instructions

SELF-INSURED GROUP NOTICE OF TERMINATION OF MEMBERSHIP

Michigan Department of Labor and Economic Opportunity
Workers' Disability Compensation Agency
P.O. Box 30016, Lansing, Michigan 48909

INSTRUCTIONS: SEE REVERSE SIDE

1. Employer Federal ID Number			
2. Name of Business(es)			
3. Owner of Business (if applicable)			
4. Business Address (Street Number and Name)	City	State	ZIP Code
5. Self-Insured ID Number	6. Name of Self-Insured Group		
7. Effective Date of Termination			

8. The employer's membership is cancelled and all business names and addresses operating under the Federal ID Number listed in item #1 are terminated for the following reason:

- ☐ A. Non-payment of premium
- ☐ B. Employer insuring elsewhere
- ☐ C. Employer no longer in business
- ☐ D. Employer uncooperative
- ☐ E. Other (provide reason) _____

Failure to maintain required insurance may subject the employer to a fine of $1,000 per day and imprisonment up to six months.

9. The employer's membership remains active and only the business name(s) listed in item #2 is being terminated for the following reason:

- ☐ F. Name change (provide new name) _____
- ☐ G. Sold entity (provide new owner name, if known) _____
- ☐ H. Entity of employer no longer in business _____
- ☐ I. Other (provide reason) _____

Pursuant to the Workers' Disability Compensation Act, this is to certify that the undersigned self-insured group has terminated the membership on the above-referenced employer. The employer has been provided a copy of this notice.

10. Authorized Signature	Date

LEO is an equal opportunity employer/program. Auxiliary aids, services and other reasonable accommodations are available upon request to individuals with disabilities.	Authority: Workers' Disability Compensation Act 418.611(2); R408.43g(4) Completion: Mandatory Penalty: Failure to file is punishable under R408.43h(2)

Print Reset

Purpose of Form WC-651:
To notify the Michigan Workers' Disability Compensation Agency (Agency) of the termination of an employer's membership in a self-insured group.

When Required:
- Must be filed with the Agency at least 20 days prior to the effective date of termination.
- Only one copy should be filed with the Agency.
- Must be used to terminate membership for an employer, to show a name change, or to show that an entity of the employer has been sold or is out of business.
- One copy must be sent to the employer.

General Guidelines for Filing Form WC-651:
(a) If there is a name change, Form WC-651 must be filed showing the old name, the date of the name change, and item #9, reason F, must be completed. The new name should be noted. Form WC-650 must be filed at the same time showing the new name and the effective date of the change.
(b) If there is only an address change, Form WC-650 and Form WC-651 should not be filed. A letter addressed to the Agency referencing the business name, owner name, the employer Federal ID Number, and showing the addition or deletion of the address by date is sufficient.

INSTRUCTIONS FOR COMPLETION

Item #1 – Employer Federal Identification Number
Enter the employer's Federal Identification Number or Social Security Number shown on the Form WC-650. This number is **required** on all Form WC-651 filings.

Item #2 – Name of Business
Enter the name(s) of the business(es) which are to be cancelled from the membership. If all names and addresses of the business are to be cancelled, list only the primary employer name and address and the owner name, and complete item #8. If you intend to continue the policy in force and only wish to cancel one or more names, complete item #9.

Item #3 – Owner Name
List the complete name of the corporation, partnership, individual, public employer, or joint venture which owns the business.

Item #4 – Business Address
List the main address, including city, state, and zip code of the business to be cancelled.

Item #5 – Self-Insured ID Number
Enter 8-digit Agency assigned self-insured group ID number and 3-digit service company ID number, if applicable.

Item #6 – Name of Self-Insured Group
The full name of the group.

Item #7 – Effective Date of Termination
Intended date of termination. Numeric (month/day/year).

Item #8 – All Entities Cancelled and Reason for Termination
Complete only if all business names, divisions, and addresses are to be terminated. Check only one reason for termination.
Check **A** if membership is cancelled for non-payment of premium.
Check **B** if employer is insuring elsewhere.
Check **C** if entire employer operating under one Federal ID Number is out of business.
Check **D** if the membership is cancelled due to the employer being uncooperative.
Check **E** if termination is for any other reason. Please note the reason.

Item #9 – Specific Entities Cancelled and Reason for Termination
Complete if membership remains active but you only wish to terminate one or more business or division names. Check only one reason for termination.
Check **F** if there is a name change for the entire business, a name change for one or more operating entities, or a change in ownership. Provide the new name. File a Form WC-650 showing the new name.
Check **G** if you continue to insure the business but one or more entities of the business have been sold. Provide new owner name if known.
Check **H** if you continue to insure the business but one or more entities of the business are dissolved or are no longer active.
Check **I** if termination is for any other reason and you continue to insure the business. Please note reason and be specific.

Item #10 – Signature of Administrator or Trustee
Must have an original signature in black or blue ink. Typed signatures are not acceptable. Include the date the form was signed.

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