

**INSURANCE CANCELLATION AGREEMENT
UNDER THE MIGRANT AND SEASONAL AGRICULTURAL WORKER
PROTECTION ACT (MSPA)**

I, _____, _____
Name/Corporation Social Security Number or License Number

hereby certify that I will provide advance notice to the designated representative of the Wage and Hour Administrator, State of Florida Department of Business & Professional Regulation, Farm Labor Registration and Testing Unit, 1940 North Monroe Street, Tallahassee, Florida 32399-1041, in the event a determination is made to cancel or otherwise discontinue any Automobile Liability or Workers' Compensation Insurance coverage which is carried for the purpose of compliance with the Migrant & Seasonal Agricultural Worker Protection Act (MSPA). The required notice of loss of insurance coverage will be sent to the address noted above at least thirty (30) days prior to the date of loss of coverage.

I understand that failure to provide the required notice constitutes a violation of MSPA. Further, I understand that I am only authorized to transport agricultural workers during those periods insurance is in effect; that should I fail to provide the advance notice as outlined above, the Wage and Hour Division, U. S. Department of Labor may revoke any certificate of registration issued to me, or otherwise refuse to renew my registration; that I hereby waive any right to a hearing on such revocation or refusal to issue/renew where such action is based on my failure to abide by this Agreement.

Applicant Signature

Subscribed and sworn to before me this _____ day of _____, 20_____

(Notary Public or Authorized Govt. Rep.)

My Commission Expires (date)

(SEAL)

Personally Known _____ OR Produced Identification _____

Type of Identification Produced _____