



CALIFORNIA
CORPORATE OFFICERS / DIRECTORS
WAIVER OF WORKERS' COMPENSATION COVERAGE

Name Insured \_\_\_\_\_ Policy Number \_\_\_\_\_
Insurer \_\_\_\_\_ Markel Insurance Company

Pursuant to California Labor Code section 3352(p), I hereby certify, under penalty of perjury, that I am an officer or director of the above-named insured, which is a quasi-public or private corporation, and that I own at least 15 percent (15%) of the issued and outstanding stock of the above-named insured corporation. As a qualifying officer or director, I elect to be excluded from the corporation's workers' compensation insurance policy with the above-referenced insurer. I understand and agree that this written waiver will be effective upon the date of receipt and acceptance by the corporation's insurer and it shall remain in effect until I provide the insurer with a written withdrawal of this waiver. I understand and agree that by signing this waiver, I will not be entitled to coverage under the insured's workers' compensation policy with the above-referenced insurer if an employment-related injury occurs.

PRINT OFFICER'S/DIRECTOR'S FULL NAME

TITLE

OFFICER/DIRECTOR SIGNATURE

DATE

ACCEPTED:

[Insurance Company]

DATE

NOTE TO EMPLOYER: The exclusion will be endorsed to the policy upon our receipt and acceptance of a signed and properly completed form. The person electing exclusion must sign this form. Company representatives may not sign on behalf of the individual. One exclusion per form. Submit additional forms if needed.

Submit forms to: CAStateExclusion@markelcorp.com or fax to 877-338-2667



CALIFORNIA  
GENERAL PARTNERS AND LLC MANAGING MEMBERS  
WAIVER OF WORKERS' COMPENSATION COVERAGE

Name Insured \_\_\_\_\_

Policy Number \_\_\_\_\_

Insurer Markel Insurance Company

Pursuant to California Labor Code section 3352(q), I hereby certify, under penalty of perjury, that I am a general partner (if the insured is a partnership) or a managing member (if the insured is a limited liability company) of the above-named insured. As a qualifying general partner or managing member, I elect to be excluded from the insured's workers' compensation insurance policy with the above-referenced insurer. I understand and agree that this written waiver will be effective upon the date of receipt and acceptance by the partnership's or limited liability company's insurer and it shall remain in effect until I provide the insurer with a written withdrawal of this waiver. I understand and agree that by signing this waiver, I will not be entitled to coverage under the insured's workers' compensation insurance policy with the above-referenced insurer if an employment-related injury occurs.

\_\_\_\_\_  
PRINT GENERAL PARTNER'S/  
MANAGING MEMBER'S FULL NAME

\_\_\_\_\_  
TITLE

\_\_\_\_\_  
GENERAL PARTNER / MANAGING MEMBER  
SIGNATURE

\_\_\_\_\_  
DATE

ACCEPTED:

\_\_\_\_\_  
[Insurance Company]

\_\_\_\_\_  
DATE

**NOTE TO EMPLOYER:** The exclusion will be endorsed to the policy upon our receipt and acceptance of a signed and properly completed form. The person electing exclusion must sign this form. Company representatives may not sign on behalf of the individual. One exclusion per form. Submit additional forms if needed.

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