CALIFORNIA

LIMITED LIABILITY COMPANY MANAGING MEMBERS – WAIVER OF WORKERS' COMPENSATION COVERAGE

NAME OF COMPANY: ______________________________________

FEIN: __________________________

POLICY #: ______________________

Pursuant to California Labor Code section 3352(q), I ______________________________________ hereby certify, under penalty of perjury, that I am a managing member of the above named insured. As a qualifying managing member of the insured, 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 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 policy with the above-referenced insurer if an employment-related injury occurs.

____ ____________________

PRINT MANAGING MEMBER'S FULL NAME TITLE

____ ____________________

MANAGING MEMBER'S SIGNATURE DATE

ACCEPTED:

____ ____________________

[Insurance Company] DATE

NOTE TO EMPLOYER: This 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: National Liability & Fire – NL&F MGU Processing
PO Box 113247, Stamford, CT 06911-3247

CALIFORNIA

CORPORATE OFFICERS/DIRECTORS - WAIVER OF WORKERS' COMPENSATION COVERAGE

NAME OF COMPANY: ______________________________

FEIN: ____________________

POLICY #: ______________________________ ____________________

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%) 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 corporations' 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 of 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'S/DIRECTOR'S SIGNATURE DATE

NOTE TO EMPLOYER: This exclusion will apply 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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