

Under California Labor Code section 3352(a), certain owners, officers, directors, general partners, and LLC managing members may waive workers' compensation coverage in writing, under penalty of perjury. Qualifying individuals are covered unless a waiver is on file. Use one form per individual. The waiver takes effect only when the insurer receives and accepts it, and some insurers require their own form; we will confirm before submitting.

1 INSURED & POLICY INFORMATION

NAMED INSURED (LEGAL NAME)		FEIN	CA ENTITY / SOS FILE NO.
MAILING ADDRESS		CITY / STATE / ZIP	

Entity type:
☐ Corporation ☐ Professional corporation ☐ Cooperative corporation ☐ Partnership ☐ Limited liability company

INSURER	POLICY NUMBER	POLICY PERIOD

This form is a (check one):
☐ New waiver (elect to be excluded) ☐ Withdrawal of a prior waiver (elect to be covered)

REQUESTED EFFECTIVE DATE	DATE OF PRIOR WAIVER (IF WITHDRAWING)

2 INDIVIDUAL INFORMATION

FULL LEGAL NAME	TITLE (PRESIDENT, CFO, GENERAL PARTNER, MANAGING MEMBER, ETC.)	
OWNERSHIP OF ISSUED AND OUTSTANDING STOCK / INTEREST (%)	EMAIL	PHONE

3 QUALIFICATION

Check the one box that applies. A withdrawal does not need this section.

A. Corporate officer or director — Labor Code 3352(a)(16)(A)(i)

I am an officer or director as described in Labor Code 3351(c) of the named insured, and I:

- ☐ Own at least 10% of the corporation's issued and outstanding stock ☐ Own at least 1%, a close family member owns at least 10%, and I have health coverage

IF 1%: FAMILY MEMBER'S NAME	RELATIONSHIP (PARENT, GRANDPARENT, SIBLING, SPOUSE, CHILD)	THEIR OWNERSHIP (%)

B. General partner or LLC managing member — Labor Code 3352(a)(17)(A)

I certify that I am:

- ☐ A general partner of the named insured partnership ☐ A managing member of the named insured limited liability company

C. Other qualifying individuals — Labor Code 3352(a)

I certify that I am:

- ☐ An owner of a professional corporation (Corp. Code 13401) who practices its profession and has health coverage
☐ An officer or director of a cooperative corporation with health coverage and a comparable disability policy
☐ A person holding the power to revoke a trust that owns the stock or interests, and I otherwise qualify above

HEALTH INSURANCE / HEALTH PLAN CARRIER (REQUIRED FOR A-1%, C)	DISABILITY POLICY CARRIER (COOPERATIVE ONLY)

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WAIVER & ACKNOWLEDGMENT

WAIVER (only for a new waiver). As a qualifying individual described in Section 3, I elect to be excluded from the named insured's workers' compensation insurance policy with the insurer named in Section 1. I understand and agree that by signing this waiver, I will not be entitled to workers' compensation benefits under that policy if I am injured or become ill at work. I understand and agree that this written waiver will be effective upon the date of receipt and acceptance by the insurer (or, with my consent, as of up to 15 days before receipt), and that it shall remain in effect until I provide the insurer with a written withdrawal of this waiver.

WITHDRAWAL (only if withdrawing). I withdraw my prior waiver and elect to be covered under the named insured's workers' compensation policy as of the date the insurer receives this withdrawal, or a later date I have requested in Section 1.

A waiver applies to the policy with the insurer named above. A new insurer may require a new waiver. Owners of professional and cooperative corporations must give a copy of the waiver to the other owners or officers, and the corporation must keep a copy on file.

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DECLARATION & SIGNATURES

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

INDIVIDUAL'S SIGNATURE (TYPE OR SIGN FULL NAME)	DATE SIGNED	EXECUTED AT (CITY, STATE)
The individual named in Section 2 must sign personally. A company representative may not sign on the individual's behalf.		
RECEIVED FOR THE BUSINESS BY (NAME / TITLE)	DATE	COPY GIVEN TO OTHER OWNERS / OFFICERS (IF REQUIRED)
PRODUCER — CORY WASHINGTON & CO. LLC	DATE SENT TO INSURER	PRODUCER SIGNATURE (TYPE FULL NAME) / DATE