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Insured Name: _____
Insurer: _____
Policy Number: _____

CORPORATE OFFICERS/DIRECTORS - WAIVER OF WORKERS' COMPENSATION COVERAGE

Pursuant to the applicable sections of California Labor Code sections 3351 and 3352 effective July 1, 2018, I hereby certify, under penalty of perjury, that I am one of the following (check one):

☐ An officer or member of the board of directors of the above-named insured, which is a quasi-public or private corporation, and that I own at least 10 percent (10%) of the issued and outstanding stock of the above-named insured corporation [CA Labor Code 3352 (a) (16) (A) (i)]; or

☐ An officer or member of the board of directors of the above-named insured, which is a quasi-public or private corporation, and I own at least one percent (1%) of the issued and outstanding stock of the corporation and my parent, grandparent, sibling, spouse, or child owns at least 10 percent (10%) of the issued and outstanding stock of the corporation and I am covered by a health insurance policy or health care service plan [CA Labor Code 3352 (a) (16) (A) (i)]; or

☐ An owner of a professional corporation, as defined in Section 13401 of the Corporations Code, and am a practitioner rendering the professional services for which the professional corporation is organized and I am covered by a health insurance policy or health care service plan [CA Labor Code 3352 (a) (18) (A) (i)]; or

☐ An officer or member of the board of directors of a cooperative corporation and I am covered by a health insurance policy or health care service plan, and a disability insurance policy that is comparable to workers' compensation coverage as determined by the California Insurance Commissioner [CA Labor Code 3352 (a) (19) (A) (i); or

☐ A person who holds the power to revoke a trust, with respect to shares of a private corporation held in trust [CA Labor Code 3351 (g)] and otherwise meet criteria for exclusion under one of the criteria listed above.

As a qualifying officer or member of the board of directors or owner as defined above, 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 OWNER/OFFICER/DIRECTOR FULL NAME TITLE

_____ _____
OWNER/OFFICER/DIRECTOR SIGNATURE DATE

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ACCEPTED:

_____
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: **Email: policysupport@accidentfund.com**
or
Mail: P.O. Box 40790, Lansing, MI 48901-7990

NER-600 B CA (ed. 07-18)