EMPLOYERS®

America's small business insurance specialist.®

Policy No/ Quote No.
Effective Date:
Writing Company:

California Waiver of Workers' Compensation Coverage

(for use with new or renewal policies with inception dates of 7/1/18 or later)

INSTRUCTIONS:

- *Enter the singular Named Insured in the box below for which you are waiving coverage*
- *Check and complete the appropriate Section (1,2,3,4 or 5) below that matches the business entity type of the Named Insured (complete only one section). Incomplete entry may result in rejection.*
- *Read the Important Notices on Page 2.*
- *Sign and date on page 2.*

Named Insured *(your employer)*
(enter one Named Insured only – see Important Notices)*

☐ **Section 1:** Named Insured is a Private or Quasi-Public Corporation

I attest that I am a working employee **and** an appointed **Corporate Officer** or **Member of the Board of Directors** of the Named Insured; **and** *(check only one box below)*

☐ I, as an individual, own at least 10% of the issued and outstanding stock; **or**

☐ I, as an individual, own at least 1% of the issued and outstanding stock of the Named Insured **and** my parent, grandparent, sibling, spouse, or child owns at least 10% of the issued and outstanding stock of the corporation **and** I am covered by a health insurance policy or a health service plan; **or**

☐ I, as an individual, own no stock, but I am a **Trustee** of a revocable trust that is a stockholder of the Named Insured. As **Trustee** I have the power to revoke the Trust's shares.

Required Entry for Section 1 Only:
Enter qualifying title of either "Corporate Officer" Or Board Member".....

☐ **Section 2**: Named Insured is a Private Professional Corporation (As defined in Section 13401 of the CA Corporations Code)

I attest that I am a working employee of the Named Insured; **and**

- I, as an individual, own stock, **and**
- I am a **practitioner** rendering professional services for which the professional corporation was organized; **and**
- I am covered by a health care service plan or health insurance policy.

Required Entry for Section 2 Only:
Enter qualifying professional corporation practitioner role .....

☐ **Section 3**: Named Insured is a Cooperative Corporation (Organized pursuant to the Cooperative Corporation Law – Corporations Code Sections 12200-12704)

I attest that I am a working employee **and** an appointed **Corporate Officer** or **Member of the Board of Directors** of the Named Insured; **and**

- I am covered by a health care service plan or health insurance policy ***and*** a disability plan that is comparable in scope and coverage to a workers compensation policy.

Required Entry for Section 3 Only:
Enter qualifying title of either "Corporate Officer" Or Board Member".....

In California, workers' compensation insurance and services may be offered through Employers Compensation Insurance Company, Employers Preferred Insurance Company and Employers Assurance Company. EIG Services, Inc. (in California, dba EIG Insurance Services) is an affiliated agency and adjuster. Not all insurers do business in all jurisdictions.

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☐ **Section 4**: Named Insured is a Limited Liability Company

I attest I am a working employee of the Named Insured; and (*Check one box only*)

☐ I am a **Managing Member; or**
☐ I am an LLC **Manager and** the **Trustee** of a Revocable Trust that is a **Member**. As trustee I have the power to revoke the Trust's interest.

☐ **Section 5**: Named Insured is a Partnership

I attest I am a working employee of the Named Insured; and (*Check one box only*)

☐ I am a **General Partner; or**
☐ I am the **Trustee** of a Revocable Trust that is a **General Partner**. As trustee I have the power to revoke the Trust's interest.

As a qualifying individual as described above, I elect to be excluded from the Named Insured's workers' compensation insurance policy. I declare under **penalty of perjury** under the laws of the State of California that the foregoing is true and correct.

I understand and agree that this written waiver will apply as of the policy effective date or no earlier than **15 days prior to EMPLOYERS date of receipt and acceptance, whichever comes later.** It shall remain in effect until I provide the insurer with a written withdrawal of this waiver. I understand and agree that I will not be entitled to coverage under the Named Insured's workers' compensation policy if an employment injury occurs.

Print Your Name	Your Signature	Date

IMPORTANT NOTICES:

- *Waiver applies per (1) person/per (1) Named Insured. If this is a multiple Named Insured policy and you qualify to waive coverage for more than one Named Insured, submit a separate waiver form for each election.
- This form may only be executed by the waiving individual. It may not be completed by any other individual including a policyholder representative or an agent.
- A confirming exclusion endorsement will be issued upon EMPLOYERS' receipt and acceptance.
  - If you do not receive an issued endorsement within a reasonable time frame, contact your agent.
  - If EMPLOYERS receives but rejects a waiver form due to incomplete entries or other errors, your agent will be notified in writing.
- Undelivered or incorrectly addressed mail or e-mail sent to EMPLOYERS is solely the sender's responsibility.
- **Submit completed forms to:**

E-mail: **westunderwriting@employers.com**
Mail: **EMPLOYERS, PO Box 539003, Henderson, NV 89053-9003**

INSURER USE ONLY	Ins. Co:	Date Rec'd:	Date Approved:	Eff. Date: