

Insured / Entity Name: _____

Insurer: Republic Indemnity

Policy No.: _____

CORPORATE OFFICERS/DIRECTORS - WAIVER OF WORKERS' COMPENSATION COVERAGE

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:

DATE

DATE

NOTE TO EMPLOYER: In accordance with SB 189, Republic Indemnity will now accept this signed waiver, provided it is received on or before December 31, 2017, and will deem it to be accepted as of January 1, 2017. The person electing exclusion must sign this form. Company representatives may not sign on behalf of the individual. One exclusion form, per entity, per excluded person. Submit additional forms if needed.

Submit forms to: Republic Indemnity
15821 Ventura Blvd., Suite 370
Encino CA 91436
Attn: Policy Services

Or you may e-mail to: AB2883@ri-net.com

Insured / Entity Name: _____

Insurer: Republic Indemnity _____

Policy No.: _____

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

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:

DATE

NOTE TO EMPLOYER: In accordance with SB 189, Republic Indemnity will now accept this signed waiver, provided it is received on or before December 31, 2017, and will deem it to be accepted as of January 1, 2017. The person electing exclusion must sign this form. Company representatives may not sign on behalf of the individual. One exclusion form, per entity, per excluded person. Submit additional forms if needed.

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