

**CA OFFICER EXCLUSIONS WAIVER**

**Insured Name:**

**Insurer:** Midwest Employers Casualty Company

**Policy Number:**

**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.

\_\_\_\_\_  
GENERAL PARTNER/MANAGING MEMBER  
FULL NAME (PLEASE PRINT) TITLE

\_\_\_\_\_  
GENERAL PARTNER/MANAGING  
MEMBER SIGNATURE DATE

ACCEPTED:  
\_\_\_\_\_  
[Insurance Company] 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: service@berkley.net.com

Mail: BerkleyNet  
9301 Innovation Drive  
Suite 200  
Manassas, VA 20110