BerkleyNet
| a Berkley Company

Insured Name:
Insurance Company:
Policy Number:

CORPORATE OFFICER, DIRECTOR OR TRUSTEE - WAIVER OF WORKERS'COMPENSATION COVERAGE

(OTHER THAN PROFESSIONAL OR COOPERATIVE CORPORATIONS)

Pursuant to California Labor Code Section 3352(a)(16)(A)(i), I hereby certify, under penalty of perjury, that I am an officer or director as described in Labor Code section 3351(c) of the above-named insured, or am a Trustee in the above named Trust. I further certify that (initial which one applies):

_____I own at least ten percent (10%) of the issued and outstanding stock of the above named corporation, **or**;

_____I own at least one percent (1%) of the issued and outstanding stock of the above named corporation if my parent, grandparent, sibling, spouse, or child owns at least ten percent (10%) of the issued and outstanding stock of the corporation and am covered by a health insurance policy or a health service plan, **or**:

_____I am a Trustee in the above named Trust.

As a qualifying officer or director, I elect to be excluded from the corporation's workers' compensation and employer's liability insurance policy with the above-referenced insurer. Or as a qualifying Trustee, I elect to be excluded from the trust's workers' compensation and employer's liability insurance policy with the above- referenced insurer.

I understand and agree that by signing this waiver, I will not be entitled to coverage under the insured's workers' compensation and employer's liability insurance policy with the above-referenced insurer if an employment- related injury occurs.

I understand and agree that this written waiver will be effective upon the date of receipt and acceptance by the above-referenced insurer, that the insurer may elect to backdate the acceptance of the waiver up to 15 days prior to the date of receipt of the waiver, and that it shall remain in effect until I provide the insurer with a written withdrawal of this waiver.

____ _______________________
PRINT OFFICER'S/DIRECTOR/TRUSTEE'S FULL NAME TITLE

____ _______________________
OFFICER/DIRECTOR/TRUSTEE SIGNATURE DATE

NOTE TO EMPLOYER: The exclusion will be endorsed to the policy upon our receipt and acceptance of a properly completed form that is signed by the person electing exclusion. Company representatives may not sign on behalf of the individual. Only one exclusion will be accepted per form, submit additional forms if needed.

Submit form to:
Email: service@berkleynet.com
Fax: 703.586.6289
Mail: BerkleyNet | 9301 Innovation Drive, Suite 200 | Manassas, VA 20110

BerkleyNet
| a Berkley Company

Insured Name:
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PROFESSIONAL CORPORATION OWNER -
WAIVER OF WORKERS'COMPENSATION COVERAGE

Pursuant to California Labor Code Section 3352(a)(18)(A)(i), I hereby certify, under penalty of perjury, that I am an "owner" and practitioner rendering the professional services for which the professional corporation is organized of the above-named professional corporation. I further certify that (please initial):

_______I will provide a copy of the waiver to all other owners, **and**;

_______The above-named insured will retain a copy of this waiver, **and**;

_______I am covered by a health insurance policy or a health care service plan.

As a qualifying owner, I elect to be excluded from the professional corporation's workers' compensation and employer's liability insurance policy with the above-referenced insurer.

I understand and agree that by signing this waiver, I will not be entitled to coverage under the insured's workers' compensation and employer's liability insurance policy with the above-referenced insurer if an employment- related injury occurs.

I understand and agree that this written waiver will be effective upon the date of receipt and acceptance by the above-referenced insurer, that the insurer may elect to backdate the acceptance of the waiver up to 15 days prior to the date of receipt of the waiver, and that it shall remain in effect until I provide the insurer with a written withdrawal of this waiver.

____ _______________________
PRINT OWNER'S FULL NAME TITLE

____ _______________________
OWNER'S SIGNATURE DATE

NOTE TO EMPLOYER: The exclusion will be endorsed to the policy upon our receipt and acceptance of a properly completed form that is signed by the person electing exclusion. Company representatives may not sign on behalf of the individual. Only one exclusion will be accepted per form, submit additional forms if needed.

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COOPERATIVE CORPORATION OFFICER / DIRECTOR -
WAIVER OF WORKERS'COMPENSATION COVERAGE

Pursuant to California Labor Code Section 3352(a)(19)(A)(i), I hereby certify, under penalty of perjury, that I am an officer or director of the above-named insured cooperative corporation. I further certify that (please initial):

_______I will provide a copy of the waiver to all other owners, and;

_______The above-named insured will retain a copy of this waiver, and;

_______I am covered by a health insurance policy or a health care service plan, and;

_______I am covered by a disability insurance policy.

As a qualifying officer or director, I elect to be excluded from the corporation's workers' compensation and employer's liability insurance policy with the above-referenced insurer.

I understand and agree that by signing this waiver, I will not be entitled to coverage under the insured's workers' compensation and employer's liability insurance policy with the above-referenced insurer if an employment- related injury occurs.

I understand and agree that this written waiver will be effective upon the date of receipt and acceptance by the above-referenced insurer, that the insurer may elect to backdate the acceptance of the waiver up to 15 days prior to the date of receipt of the waiver, and that it shall remain in effect until I provide the insurer with a written withdrawal of this waiver.

____ ______________________
PRINT OFFICER / DIRECTOR'S FULL NAME TITLE

____ ______________________
OFFICER / DIRECTOR'S SIGNATURE DATE

NOTE TO EMPLOYER: The exclusion will be endorsed to the policy upon our receipt and acceptance of a properly completed form that is signed by the person electing exclusion. Company representatives may not sign on behalf of the individual. Only one exclusion will be accepted per form, submit additional forms if needed.

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| a Berkley Company

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

Pursuant to California Labor Code section 3352(a)(17)(A), I hereby certify 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, that the insurer may elect to backdate the acceptance of the waiver up to 15 days prior to the date of receipt of the waiver, and that 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.

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

PRINT PARTNER/MANAGER'S FULL NAME TITLE

GENERAL PARTNER'S/MANAGING MEMBER'S 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.

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