**CORPORATE OFFICERS/DIRECTORS – WAIVER OF WORKERS’ COMPENSATION COVERAGE**

**Insured Name:**

**Insurer:**

**Policy Number:**

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 corporation. 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 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 and employer’s liability insurance policy with the above-referenced insurer if an employment-related injury occurs.

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PRINT OFFICER’S/DIRECTOR’S FULL NAME TITLE DATE

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PERCENTAGE OF STOCK OWNERSHIP OFFICER/DIRECTOR SIGNATURE

ACCEPTED:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INSURER AUTHORIZED REPRESENTATIVE DATE

**NOTE TO EMPLOYER: Failure to return this form will result in all persons being included and the policy subject to additional premium. 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 to** **Prem.audit@meadowbrook.com** **Fax (877)892-0168 or via USPS to**

**Meadowbrook Insurance Group P.O. Box 219183 Kansas City MO. 64121**