

Insured Name:
Insurance Company:
Policy Number:

**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.

Submit form to:

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