

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](mailto:service@berkleynet.com)

Fax: 703.586.6289

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