**Named Insured:**
**Company:**
**Policy No.:**

## CORPORATE OFFICERS/DIRECTORS - WAIVER OF WORKERS'COMPENSATION COVERAGE

Pursuant to California Labor Code section 3352(a)(16)(A)(i), I hereby certify that I am an officer or director as described in Labor Code section 3351, subdivision (c) of the above-named insured, and that I either (1) own at least ten percent (10%) of the issued and outstanding stock of the abovenamed insured corporation, or (2) own at least one percent (1%) of the issued and outstanding stock of the 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. As a qualifying officer or director, I elect to be excluded from the corporation'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 corporation's insurer, that the insurer may elect to backdate the acceptance of the waiver up to fifteen (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 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 OFFICER'S/DIRECTOR'S FULL NAME | TITLE |
| OFFICER/DIRECTOR SIGNATURE | DATE |

**ACCEPTED:**

| | |
|---|---|
| CONTINENTAL CASUALTY 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.**

**Completed forms may be returned to: WCAB2883@cna.com or**

**CNA Insurance**
**Policy Services Department**
**PO Box 946350**
**Maitland, FL 32794**