

Named Insured:
Company:
Policy No.:

**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 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 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 GENERAL PARTNER'S/MANAGING
MEMBER'S FULL NAME

TITLE

GENERAL PARTNER/MANAGING MEMBER
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