

**OWNER/OFFICER/AFFILIATE WORKERS COMPENSATION REJECTION/EXCLUSION/INCLUSION
FORM**

Pursuant to State Worker's Compensation Law

Depending on the state your business resides in, an Officer, Partner, Member, manager, Sole Proprietor or other individual may be required/permitted to elect or reject workers compensation coverage. This document provides record of your decision as your state has not provided a specific form for this purpose. The coverage indicated below will be applied to all subsequent renewal policies until Sirius Insurance has been notified in writing of change in coverage.

Please fill in all sections that pertain to your company, sign and return to us.

Business Name:			
Mailing address:			
Contact Person:			
Phone number:			
Entity type:	<input type="checkbox"/> Corporation	<input type="checkbox"/> Sole Proprietor	<input type="checkbox"/> Partnership
	<input type="checkbox"/> Limited Liability Company	<input type="checkbox"/> Other	

Select only one choice below:

- The person named below is choosing to be Included
- The person named below is choosing to be Excluded/Rejected
- The person named below is choosing to withdraw their previous inclusion of coverage
- The person named below is choosing to withdraw their previous exclusion/rejection of coverage

Type of Individual(s):	<input type="checkbox"/> Officer /Title	<input type="checkbox"/> Sole Proprietor
	<input type="checkbox"/> Member	<input type="checkbox"/> Partner
Name of Individuals:		

Authorized by:

Print Full Name:	Title:
Signature:	Date:
Effective Date of Coverage:	