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| **Application for Exclusion of Officers and Stockholders** |  |

F11=Navigate

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| --- | --- |
| Name of Corporation: |  |

|  |  |
| --- | --- |
| Address of Corporation: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Insurance Company: |  | Policy Number |  |

We the officers and stockholders of the above mentioned corporation elect to be individually excluded from our Workers’ Compensation Insurance policy:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Officer Name** |  | **Signature** |  | **Title** |  | **% Ownership** |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

A copy of the corporate board resolution authorizing this exclusion is attached.

Subscribed and sworn to before me this \_\_\_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_\_. Counter signed

by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Notary Public of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ County, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

My commission expires on the \_\_\_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_\_.

Office use only:

Date received by Carrier Company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Retain