CALIFORNIA – COOPERATIVE CORPORATION -
WAIVER OF WORKERS' COMPENSATION COVERAGE

Insured Name: _____

FEIN: _____

Policy #: _____

Insurer:

biBERK:
- ☐ Berkshire Hathaway Direct Insurance Company
- ☐ National Liability & Fire Insurance Company
- ☐ Wellfleet Insurance Company
- ☐ Wellfleet New York Insurance Company

Pursuant to California Labor Code, I hereby certify that I am an officer or member of the board of directors of a cooperative corporation organized pursuant to the Cooperative Corporation law set forth in the Corporation Code. I understand that I may waive workers' compensation coverage by executing a document, in writing and under penalty of perjury, waiving my workers' compensation rights and stating that I am covered by a health care service plan or health insurance policy, and a disability insurance policy that is comparable in scope and coverage to a workers' compensation insurance policy. (The Insurance Commissioner shall determine whether a disability policy is comparable in scope and coverage to a workers' compensation insurance policy.)

With this waiver, I elect to be excluded from the cooperative 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 cooperative corporation's 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. 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 understand that I must provide a copy of this waiver to all officers and members, and the cooperative corporation must keep a copy of the waiver on file.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

DATED: _____

_____ _____

OFFICER'S/MEMBER'S SIGNATURE PRINT OFFICER'S/MEMBER'S FULL NAME/TITLE

ACCEPTED:

_____ _____

INSURANCE 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.

Submit forms to: biBERK
PO Box 110083, Stamford, CT 06911