Clear Form

LLC MANAGING MEMBERS –

WAIVER OF WORKERS' COMPENSATION COVERAGE

Insured (Policyholder) Name: _____
(PRINT FULL NAME OF INSURED EMPLOYER / POLICYHOLDER)

Policy No.: _____
(LEAVE BLANK IF POLICY NOT YET ISSUED)

Insurer: **State Compensation Insurance Fund (State Fund)**

Pursuant to California Labor Code section 3352(a)(17)(A), I hereby certify, under penalty of perjury, that I am a qualifying managing member of the above-named insured, which is a limited liability company. As a qualifying managing member, I elect to be excluded from the insured's workers' compensation insurance policy with State Compensation Insurance Fund (State Fund). I understand and agree that this written waiver will be effective upon the date of receipt and acceptance by the firm'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 State Fund under any circumstances, including if an employment-related injury occurs.

_____ _____
PRINT FULL NAME OF LLC MANAGING MEMBER TO BE EXCLUDED **TITLE**

_____ _____
SIGNATURE OF LLC MANAGING MEMBER TO BE EXCLUDED **DATE**

NOTE TO EMPLOYER: The exclusion will be endorsed to the policy by State Fund upon State Fund's receipt and acceptance of a signed and properly completed form. The person electing exclusion from the policy must sign this form. Company representatives of the employer may not sign on behalf of the individual being excluded. One exclusion per form - submit additional forms if needed.

State Fund Internal Use Only: **ACCEPTED by State Fund:** **Yes / No** **Date of Acceptance:** _____