ICWGROUP
Insurance Companies

Print

Insured Name:

Insurer: Insurance Company of the West
Policy No.:

CORPORATE OFFICERS/DIRECTORS - WAIVER OF WORKERS' COMPENSATION COVERAGE

Pursuant to California Labor Code section 3352(p), I hereby certify, under penalty of perjury, that I am an officer or director of the above-named insured, which is a quasi-public or private corporation, and that I own at least 15 percent (15%) of the issued and outstanding stock of the above-named insured corporation. As a qualifying officer or director, I elect to be excluded from the 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 corporation's insurer and 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 policy with the above-referenced insurer if an employment-related injury occurs.

PRINT OFFICER'S/DIRECTOR'S FULL NAME

CORPORATE TITLE (i.e.: PRESIDENT, VP, SEC, TREAS, etc.)

OFFICER/DIRECTOR SIGNATURE

DATE

EMAIL ADDRESS

NOTE TO EMPLOYER: The exclusion will be endorsed to the policy upon our receipt and acceptance of a completed and signed 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 as needed.

Mail form(s) to:

ICW Group
AB2883
PO Box 509039
San Diego, CA 92150-9039

Or, email signed and scanned copy(s) to:

AB2883@ICWGroup.com

Below to be completed by ICW Group

ACCEPTED:

[Insurance Company]

DATE