Print

ICWGROUP
Insurance Companies

**Insured Name:**

**Insurer:** Insurance Company of the West
**Policy No.:**

## GENERAL PARTNERS AND LLC MANAGING MEMBERS - WAIVER OF WORKERS' COMPENSATION COVERAGE

Pursuant to California Labor Code section 3352(q), I hereby certify, under penalty of perjury, that I am a general partner (if the insured is a partnership) or a managing member (if the insured is a limited liability company) of the above-named insured. As a qualifying general partner or managing member, I elect to be excluded from the insured'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 partnership's or limited liability company'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 insurance policy with the above-referenced insurer if an employment-related injury occurs.

_____ _____

PRINT GENERAL PARTNER'S/
MANAGING MEMBER'S FULL NAME

TITLE**

**Please note: If General Partner, then title must say "General Partner". If Managing Member, then title must say "Managing Member".

_____ _____

GENERAL PARTNER/MANAGING MEMBER
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

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**Below to be completed by ICW Group**

ACCEPTED:

_____ _____

[Insurance Company] DATE