ICW GROUP Insurance Companies

SB189 CORPORATE OFFICERS DIRECTOR WAIVER

PRINT

FOR POLICIES WITH START DATE OF JULY 1, 2018 AND LATER

Insured Name: _____ **Insurer:** _____

Policy Number: _____

WAIVER OF WORKERS' COMPENSATION COVERAGE

Pursuant to California Labor Code section 3352(a) sections (16)(A)(i), (17)(A), (18)(A)(i), (19)(A)(i):
I hereby certify that I am one of the following:

CORPORATIONS

- An **officer or director** as described in Labor Code section 3351, subdivision (c) of the above-named insured, and that I either:
  (1) **own at least ten percent (10%)** of the issued and outstanding stock of the above-named insured corporation, or
  (2) **own at least one percent (1%)** of the issued and outstanding stock of the corporation if my parent, grandparent, sibling, spouse, or child owns at least ten percent (10%) of the issued and outstanding stock of the corporation and am covered by a health insurance policy or a health service plan
- An owner of a professional corporation, as defined in Section 13401 of the Corporations Code, who is a practitioner rendering the professional services for which the corporation is organized and I am covered by a health insurance policy or a health care service plan
- An officer or member of the board of directors of a **cooperative corporation** and covered by both a health care service plan or health insurance policy and a disability insurance policy comparable to a work comp policy

PARTNERSHIPS AND LLC'S

- I hereby certify that I am a **general partner** (if the insured is a partnership), or
- I hereby certify that I am a **managing member** (if the insured is a limited liability company)

As a qualifying officer, director, partner, managing member, or person holding the power to revoke a trust with respect to the ownership of one of these entities, I elect to be excluded from the named 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 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 policy with the above-referenced insurer if an employment-related injury occurs.

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

PRINT FULL NAME _____ TITLE (i.e.: President, Vp, Sec, Treas, General Partner, Managing Member, etc.) _____

SIGNATURE _____ DATE _____

EMAIL ADDRESS _____

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 individual per form. Submit additional forms if needed.

Mail form(s) to:
Insurance Company of the West
Attn: WCU Policy Processing
PO Box 509039
San Diego, CA 92150-9039

Or, email signed and scanned copy(s) to:
SCEprocessing@icwgroup.com

Acceptance to be completed by ICW Group

ACCEPTED: [INSURANCE COMPANY] _____ DATE _____

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