AmTrust North America
An AmTrust Financial Company

WAIVER FORM

Insured Name:
Insurer:
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 Title

_____ _____
Officer/Director Signature Date

Accepted:

_____ _____
Insurer Authorized Representative 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.

Email your forms to your company representative, or mail them via the USPS to:
AmTrust North America
800 Superior Avenue E., 21st Floor
Cleveland, OH 44114

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An AmTrust Financial Company

WAIVER FORM

Insured Name:
Insurer:
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/Full Name Title
Managing Member's Full Name

_____ _____
General Partner/Managing Member Signature Date

Accepted:

_____ _____
Insurer Authorized Representative 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.

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