LLC MANAGING MEMBERS –

WAIVER OF WORKERS' COMPENSATION COVERAGE

Insured (Policyholder) Name: _____
(PRINT FULL NAME OF 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(q), 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 State Fund, and it shall remain in effect until State Fund receives and accepts a written withdrawal of this waiver from me. 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 the 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:

DATE RECEIVED AND ACCEPTED: _____ **NOTE:** _____