Clear Form

STATE COMPENSATION INSURANCE FUND

CORPORATION WAIVER FORM (*Effective on and after 7/1/18*)

Insured Name: _____

Policy No: _____ (LEAVE BLANK IF POLICY NOT YET ISSUED)

CORPORATE OFFICERS/DIRECTORS
WAIVER OF WORKERS' COMPENSATION COVERAGE

The individual electing to be excluded from the workers' compensation policy must meet one of the following sets of requirements (based on the corporation's entity type) in order to qualify for exclusion. You must check the box for the exclusion from workers' compensation insurance that the person signing this form is qualified to make.

☐	**CORPORATION** Pursuant to California Labor Code section 3352(a)(16)(A)(i), I hereby certify that I am an **officer or member of the board of directors,** as described in Labor Code Section 3351 (c), of the above-named insured, which is a quasi-public or private corporation, and that **I own at least 10 percent (10%)** of the issued and outstanding stock of the above-named insured corporation.
☐	**CORPORATION** Pursuant to California Labor Code section 3352(a)(16)(A)(i), I hereby certify that I am **an officer or member of the board of directors**, as described in Labor Code Section 3351 (c), and that **I own at least 1 percent of the issued and outstanding stock of the corporation and that my parent, grandparent, sibling, spouse, or child owns at least 10 percent** of the issued and outstanding stock of the corporation and that **I am covered by a health insurance policy or a health care service plan.**
☐	**PROFESSIONAL CORPORATION** Pursuant to California Labor Code section 3352(a)(18)(A)(i), I hereby certify that I am **an owner**, as described in Corporations Code Section 13401, and I am a **practitioner rendering professional services for which the professional corporation is organized and that I am covered by a health insurance policy or a health care service plan.**

As a qualifying officer, director or owner, I elect to be excluded from the workers' compensation insurance policy issued by State Compensation Insurance Fund ("State Fund"). I made a check mark in the box for the exclusion from workers' compensation insurance that I am qualified to make. I understand and agree that this written waiver will be effective upon the date of receipt and acceptance by State Fund, that State Fund may elect to backdate the acceptance of the waiver up to 15 days prior to the date of receipt of the waiver, and that the waiver shall remain in effect until I provide State Fund 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 issued by State Fund 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.

DATE: _____ Ownership Percentage: _____

_____ _____

OFFICER/DIRECTOR/OWNER SIGNATURE PRINT OFFICER'S/DIRECTOR'S/OWNER'S FULL NAME/TITLE

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. Only one person can be excluded per form. Submit additional forms if needed.

State Fund Internal Use Only: **ACCEPTED by State Fund:** **Yes / No** **Date of Acceptance:** _____