IMPORTANT NOTICE REGARDING INDIVIDUALS EXCLUDED FROM YOUR POLICY
IMMEDIATE RESPONSE REQUIRED

<Date>

<Policyholder Name>
<Mailing Address>
<City>, <State>, <Zip>

Re: Notice of Change in Law Effective 1/1/17 due to AB 2883
General Partner Exclusions on your STATE FUND WC policy
<Policy #>

Dear Policyholder:

There has been a significant change in California Workers' Compensation Law that takes effect January 1, 2017 and may affect the coverage and premiums on your current and future workers' compensation policies. *So please read this letter carefully and follow the instructions outlined to ensure your policy is compliant with the new law*.

AB 2883 was signed into law August 26, 2016 and amends Labor Code sections 3351 and 3352 changing the definition of "employee" and the eligibility criteria to elect exclusion from workers' compensation coverage. Beginning January 1, 2017 all workers' compensation insurance policies will be required to cover certain officers and directors of private or quasi-public corporations and working members of partnerships and limited liability companies that may have been previously excluded from coverage.

The legal entity of your business is identified as a **partnership** on your policy with State Fund. Under AB 2883 the following changes become effective for all partnerships on 1/1/2017 regardless of the inception date of the policy:

> Effective January 1, 2017, in order for a General Partner of a partnership to be excluded from the WC policy, the General Partner must sign a new Wavier of workers' compensation benefits, under penalty of perjury. Each General Partner who is electing exclusion from WC coverage must sign a separate Waiver Form.

To ensure that your workers' compensation insurance policy complies with the new law, State Fund must confirm which of your General Partners are eligible to elect exclusion by obtaining new signed Waiver Forms for them. If previously-excluded individuals are no longer eligible for exclusion under the new law, State Fund is required to add these individuals to your policy as of 1/1/2017 (and on future policies), as well as, add their payroll to the calculation of your estimated annual premium (subject to the Workers' Compensation Insurance Rating Bureau's minimum / maximum payroll rules, where applicable).

<Policyholder Name>
<Policy #>

Our objective is to help you achieve compliance with this new law. In order for you to continue to exclude qualifying individuals from your WC policy, you must complete the information requested in this notice and return it to State Fund. In compliance with AB 2883, State Fund will automatically expire the following endorsements as of 12/31/2016:

Endorsement 1600 – Corporate Officers and Directors Excluded
Endorsement 1700 – General Partners Excluded
Endorsement 1901 – Limited Liability Company Managers-Members Excluded

New endorsements will be added to your policy effective 1/1/2017, if you provide the necessary documentation as outlined in this notice.

Instructions:

Please follow the AB 2883 Compliance Guide on page 3 of this notice and return the information requested including all signed forms, as appropriate (pages 4 & 5). Please note that separate signed forms will be required for each individual, according to their exclusion or inclusion.

Response Options:

1. By e-mail: scan and email your completed package to State Fund at: WaiverForm@scif.com as soon as possible, but no later than **December 31, 2016**.

2. If you prefer to mail via USPS: please mail your completed package to: **State Fund – Attn: Waiver Response Team, PO Box 969000, Vacaville, CA 95696-9000.** Please ensure receipt by State Fund no later than **December 31, 2016**.

If the waivers are not returned by the December 31st, 2016 deadline, State Fund will be required under the new law to include all general partners on the policy, which will increase your premium.

Thank you for your attention to this important information. We appreciate your business and are committed to working with our policyholders to comply with this new law.

If you have questions, please contact your Broker or contact a State Fund Representative toll free at **888-STATEFUND** (**888-782-8338**).

Sincerely,

STATE COMPENSATION INSURANCE FUND

<Policyholder Name>
<Policy #>

Step 1 – List of All General Partners of your Partnership

In the space below, please list each **General Partner** of your partnership:
.

First and Last Name of General Partners

1.

2.

3.

4.

-*Please provide additional page, if needed*-

Step 2 – Qualifying Individuals – Complete and Sign the Waiver Form

Each General Partner of the partnership who wishes to be excluded from coverage under the State Fund policy must sign a new written **Waiver** of workers' compensation benefits under penalty of perjury certifying that he or she is a qualifying General Partner. A copy of the required **Waiver Form** is attached. Please make additional copies of the Waiver Form as needed.

Each Waiver Form must be signed by the individual to be excluded and not by an employer or employer representative. The exclusion of the General Partner(s) will be effective as of 1/1/2017, or as of the date we receive and accept properly completed and signed Waiver Forms (if received after 1/1/2017). If you provide the necessary signed waivers by 12/31/2016, your policy will not reflect a premium charge for qualifying individuals who elect to be excluded.

Step 3 – Currently Excluded Individuals Who Are Ineligible to Elect Exclusion

Each General Partner who needs to be included under the policy (but is currently excluded) will need to complete a **Coverage Questionnaire for Included Individuals** form. A copy of this form is attached. Your policy will reflect a premium charge for these individuals.

Thank you for attention to this important matter.

Please return the necessary documents (including this completed page) as soon as possible – but no later than 12/31/16. If you are returning multiple signed forms, please return them together so that they may be processed efficiently.

<Policyholder Name>
<Policy #>

GENERAL PARTNERS –

WAIVER OF WORKERS' COMPENSATION COVERAGE

Insured (Policyholder) Name: ______________________________

(PRINT FULL NAME OF EMPLOYER / POLICYHOLDER)

Policy No.: ______________________________

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 General Partner of the above-named insured, which is a partnership. As a qualifying General Partner, 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 GENERAL PARTNER TO BE EXCLUDED **TITLE**

______________________________ ______________________________

SIGNATURE OF GENERAL PARTNER TO BE EXCLUDED **DATE**

NOTE TO EMPLOYER: 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 excluded individual per form. If this form is properly completed and signed, the exclusion of the qualifying individual will be endorsed to the policy by State Fund effective 1/1/2017, or as of the date of receipt and acceptance by State Fund (if received after 1/1/2017).

STATE FUND INTERNAL USE ONLY: **Waiver Form (GENERAL PARTNERS) – Ed. 10/2016**

DATE RECEIVED AND ACCEPTED: ______________________ **NOTE:** ______________________

<Policyholder Name>
<Policy #>

Coverage Questionnaire for Included Individuals

Corporate Officers / Directors / Partners / LLC Managing-Members

Please complete this form for each Corporate Officer, Director, General Partner or Managing-Member who is not eligible to elect exclusion from your WC policy (or is eligible to elect exclusion but has elected to be included on the WC policy). One form per individual. Failure to complete this questionnaire with sufficient detail may impact our ability to accurately update your policy.

Corporate Officer / Director / Partner / Managing-Member____
(Name of Person)

Policy # _____________________________ ____
(Title of Person)

Employer Name ____
(Name of Entity) (Legal Entity Type)

List the **annual compensation (salary and bonus)** of above Officer / Director / Partner / Managing-

Member ____

PLEASE DESCRIBE job duties of the Corporate Officer, Director or Partner or LLC Managing-Member, including physical operations performed, daily routines, and work locations visited.
Please note: "administration" or "management" are insufficient job duty descriptions.

____

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____

____
(*please add additional pages to explain, if necessary)*

If supervision is performed by this individual, what operations are being supervised?

____

____

If sales are a job duty by this individual, estimate percentage of inside and outside sales work.

____

____
Signature of Corporate Officer/Director/Partner/Managing-Member Title Date