OWNER OF PROFESSIONAL CORPORATION -
WAIVER OF CALIFORNIA WORKERS' COMPENSATION COVERAGE

Insured / Entity Name: _____

Insurer: **Republic Indemnity Company of America / Republic Indemnity Company of California**

Policy No.: _____

Pursuant to California Labor Code section 3352(a)(16)(A)(i), I hereby certify under penalty of perjury that I am an owner (as defined in Section 13401 of the California Corporations Code) of the above-named insured professional corporation (insured); I am a practitioner rendering professional services for which the professional corporation is organized; and I am covered by a health insurance policy or a health service plan. As a qualifying owner of the named insured, I elect to be excluded from the insured's workers' compensation insurance policy with the above-named 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 acceptance of the waiver up to 15 days prior to the date of receipt of the waiver; and that this waiver 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 if an employment-related injury occurs. I further certify that I have provided a copy of this waiver to all other owners of the professional corporation; and the professional corporation has, and will maintain a copy of this waiver on file.

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

DATE: _____

_____ _____

OWNER'S SIGNATURE PRINT OWNER'S FULL NAME & TITLE

ACCEPTED:

_____ _____

[Insurance Company] DATE

NOTE TO EMPLOYER: The exclusion will be endorsed to the policy upon insurer's receipt and acceptance of a properly completed and signed form. The owner electing exclusion must personally sign this form. Corporate representatives may not sign on behalf of the owner to be excluded. Stamped signatures will not be accepted. One exclusion is permitted per form.

The insurer (carrier), insurance agent, or insurance broker is not required to investigate. verify, or confirm the accuracy of the facts contained in this waiver. There is a conclusive presumption that the person executing this waiver is not covered by workers' compensation benefits.

Send signed Waivers by email (preferred method) to AB2883@ri-net.com,

Or mail original to: Republic Indemnity
4500 Park Granada #300
Calabasas, CA 91302
Attention: Policy Services

(Ed. 07-18)