**TRUSTEE WITH THE POWER TO REVOKE GENERAL PARTNERSHIP INTERESTS HELD IN TRUST, LIMITED LIABILITY INTERESTS HELD IN TRUST OR CORPORATE INTERESTS HELD IN TRUST - 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)(17)(A), I hereby certify under penalty of perjury that I am the trustee with the power to revoke the trust of the above-named insured general partnership held in trust, limited liability company interests held in trust, or private corporation interests held in trust, and am qualified to 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 partnership's, limited liability company's, or corporation's insurer; that the insurer may elect to backdate the 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 insurance policy with the above-referenced insurer 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: _____

_____ _____

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 person electing exclusion must personally sign this form. Stamped signatures will not be accepted. Company representatives may not sign on behalf of the individual. 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)