COOPERATIVE CORPORATION OFFICER OR BOARD MEMBER -
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 3351 & 3352, Subsection 3352(a)(19), I hereby certify under penalty of perjury that I am an "officer or member of the board of directors of a cooperative corporation organized pursuant to the Cooperative Corporation Law, as set forth in Part 2 (commencing with Section 12200) of Division 3 of Title 1 of the California Corporations Code"; that I provide services for pay for the insured Cooperative Corporation; and that I am "covered by both a health care service plan or health insurance policy, and a disability insurance policy that is comparable in scope and coverage, as determined by the Insurance Commissioner, to a workers' compensation policy"; I am knowingly executing this written waiver of my rights and wish to be excluded from the California workers' compensation laws. I understand and agree that this written waiver will be effective upon the date of receipt and acceptance by the cooperative 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 will provide a copy of this waiver to all other officers and members of the board of directors of the cooperative corporation.

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 the 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
15821 Ventura Blvd., Suite 370
Encino, CA 91436
Attention: Policy Services

(Ed. 07-18)