

California Officer Waiver of Coverage Checklist

California SB 189 applies to excluded officers on policies with primary locations in California incepting on or after July 1, 2018.

- **Initial review of executive(s) and company ownership**

___ Review all company officers, directors, owners, general partners or managing members to determine if they are eligible for exclusion

- **Present a Waiver of Coverage form to eligible owners to be excluded**

___ Choose waiver form applicable to entity type per guidelines below
___ One form per person

- **Forward completed and signed forms to BerkleyNet**

___ Submit forms using one of these options:
Email: service@berkley.net
Fax: 703.586.6289
Mail: BerkleyNet | 9301 Innovation Drive, Suite 200 | Manassas, VA 20110

Important Note: *Exclusion will be effective upon the date we receive and accept the signed Waiver Form. We may elect to backdate the acceptance of the waiver up to 15 days prior to receipt.*

- **Submit endorsement request for any changes in ownership immediately**

Guidelines for Exclusion and Choosing Correct Form

Corporations (Other Than Professional or Cooperative Corporations) and Trusts – Labor Code Section 3352(16) – An Officer or Director who owns a minimum of 10% of the stock or an Officer or Director who is covered by health insurance and owns at least 1% of the stock with a parent, grandparent, sibling, spouse, or child owning at least 10% of the stock, or a Trustee of a Trust may elect exclusion from their workers' compensation insurance policy. Each qualifying Officer, Director, or Trustee must sign a Waiver of Coverage form stating, under penalty of perjury, that s/he is eligible for exclusion.

Professional Corporations – Labor Code 3352(18) – Owners covered by health insurance may elect exclusion from their workers' compensation insurance policy, regardless of their ownership percentage. Each Owner who elects exclusion must sign and date a Waiver of Coverage form stating, under penalty of perjury, that s/he is eligible for exclusion and provide a copy of the Waiver to all other owners of the professional corporation. The professional corporation shall keep a copy of the waiver on file.

Cooperative Corporations – Labor Code 3352(19) – An Officer or Director covered by health insurance and a disability policy may elect exclusion from their workers' compensation insurance policy, regardless of their ownership percentage. Each qualifying Officer or Director must sign a Waiver of Coverage form stating, under penalty of perjury, that s/he is eligible for exclusion and provide a copy of the Waiver to all other owners of the cooperative corporation. The cooperative corporation shall keep a copy of the waiver on file.

Partnerships and Limited Liability Companies – Labor Code Section 3352(17) – General Partners or Managing Members of LLC's may elect exclusion from their workers' compensation insurance policy. Each qualifying General Partner or Managing Member must sign a Waiver of Coverage form stating, under penalty of perjury, that s/he is eligible for exclusion.

Insured Name:
Insurance Company:
Policy Number:

**CORPORATE OFFICER, DIRECTOR OR TRUSTEE -
WAIVER OF WORKERS' COMPENSATION COVERAGE**

(OTHER THAN PROFESSIONAL OR COOPERATIVE CORPORATIONS)

Pursuant to California Labor Code Section 3352(a)(16)(A)(i), I hereby certify, under penalty of perjury, that I am an officer or director as described in Labor Code section 3351(c) of the above-named insured, or am a Trustee in the above named Trust. I further certify that (initial which one applies):

_____ I own at least ten percent (10%) of the issued and outstanding stock of the above named corporation, **or**;

_____ I own at least one percent (1%) of the issued and outstanding stock of the above named corporation if my parent, grandparent, sibling, spouse, or child owns at least ten percent (10%) of the issued and outstanding stock of the corporation and am covered by a health insurance policy or a health service plan, **or**:

_____ I am a Trustee in the above named Trust.

As a qualifying officer or director, I elect to be excluded from the corporation's workers' compensation and employer's liability insurance policy with the above-referenced insurer. Or as a qualifying Trustee, I elect to be excluded from the trust's workers' compensation and employer's liability insurance policy with the above-referenced insurer.

I understand and agree that by signing this waiver, I will not be entitled to coverage under the insured's workers' compensation and employer's liability insurance policy with the above-referenced insurer if an employment-related injury occurs.

I understand and agree that this written waiver will be effective upon the date of receipt and acceptance by the above-referenced 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 it shall remain in effect until I provide the insurer with a written withdrawal of this waiver.

PRINT OFFICER'S/DIRECTOR/TRUSTEE'S FULL NAME

TITLE

OFFICER/DIRECTOR/TRUSTEE SIGNATURE

DATE

NOTE TO EMPLOYER: The exclusion will be endorsed to the policy upon our receipt and acceptance of a properly completed form that is signed by the person electing exclusion. Company representatives may not sign on behalf of the individual. Only one exclusion will be accepted per form, submit additional forms if needed.

Submit form to:

Email: service@berkleynet.com

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Mail: BerkleyNet | 9301 Innovation Drive, Suite 200 | Manassas, VA 20110

Insured Name:
Insurance Company:
Policy Number:

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

Pursuant to California Labor Code Section 3352(a)(18)(A)(i), I hereby certify, under penalty of perjury, that I am an "owner" and practitioner rendering the professional services for which the professional corporation is organized of the above-named professional corporation. I further certify that (please initial):

_____ I will provide a copy of the waiver to all other owners, **and**;

_____ The above-named insured will retain a copy of this waiver, **and**;

_____ I am covered by a health insurance policy or a health care service plan.

As a qualifying owner, I elect to be excluded from the professional corporation's workers' compensation and employer's liability insurance policy with the above-referenced insurer.

I understand and agree that by signing this waiver, I will not be entitled to coverage under the insured's workers' compensation and employer's liability insurance policy with the above-referenced insurer if an employment-related injury occurs.

I understand and agree that this written waiver will be effective upon the date of receipt and acceptance by the above-referenced 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 it shall remain in effect until I provide the insurer with a written withdrawal of this waiver.

PRINT OWNER'S FULL NAME

TITLE

OWNER'S SIGNATURE

DATE

NOTE TO EMPLOYER: The exclusion will be endorsed to the policy upon our receipt and acceptance of a properly completed form that is signed by the person electing exclusion. Company representatives may not sign on behalf of the individual. Only one exclusion will be accepted per form, submit additional forms if needed.

Submit form to:

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Mail: BerkleyNet | 9301 Innovation Drive, Suite 200 | Manassas, VA 20110

Insured Name:
Insurance Company:
Policy Number:

**COOPERATIVE CORPORATION OFFICER / DIRECTOR -
WAIVER OF WORKERS' COMPENSATION COVERAGE**

Pursuant to California Labor Code Section 3352(a)(19)(A)(i), I hereby certify, under penalty of perjury, that I am an officer or director of the above-named insured cooperative corporation. I further certify that (please initial):

- _____ I will provide a copy of the waiver to all other owners, and;
- _____ The above-named insured will retain a copy of this waiver, and;
- _____ I am covered by a health insurance policy or a health care service plan, and;
- _____ I am covered by a disability insurance policy.

As a qualifying officer or director, I elect to be excluded from the corporation's workers' compensation and employer's liability insurance policy with the above-referenced insurer.

I understand and agree that by signing this waiver, I will not be entitled to coverage under the insured's workers' compensation and employer's liability insurance policy with the above-referenced insurer if an employment-related injury occurs.

I understand and agree that this written waiver will be effective upon the date of receipt and acceptance by the above-referenced 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 it shall remain in effect until I provide the insurer with a written withdrawal of this waiver.

_____	_____
PRINT OFFICER / DIRECTOR'S FULL NAME	TITLE
_____	_____
OFFICER / DIRECTOR'S SIGNATURE	DATE

NOTE TO EMPLOYER: The exclusion will be endorsed to the policy upon our receipt and acceptance of a properly completed form that is signed by the person electing exclusion. Company representatives may not sign on behalf of the individual. Only one exclusion will be accepted per form, submit additional forms if needed.

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Insured Name:
Insurance Company:
Policy Number:

**GENERAL PARTNERS AND LLC MANAGING MEMBERS -
WAIVER OF WORKERS' COMPENSATION COVERAGE**

Pursuant to California Labor Code section 3352(a)(17)(A), I hereby certify that I am a general partner (if the insured is a partnership) or a managing member (if the insured is a limited liability company) of the above-named insured. As a qualifying general partner or managing member, I elect to be excluded from the insured's workers' compensation insurance policy with the above-referenced insurer. I understand and agree that this written waiver will be effective upon the date of receipt and acceptance by the partnership's or limited liability company'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 it 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.

PRINT PARTNER/MANAGER'S FULL NAME TITLE

GENERAL PARTNER'S/MANAGING MEMBER'S SIGNATURE DATE

ACCEPTED:

[Insurance Company] DATE

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. One exclusion per form. Submit additional forms if needed.

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