AF Group
Individual focus. Collective strength.

Insured Name: _____
Insurer: _____
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, under penalty of perjury, 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 and 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.

Pursuant to California Labor Code Section 3351 (g), I understand that if I hold the power to revoke a trust with respect to general partnership or limited liability company interests held in trust and am deemed to be an employee as described under subdivisions (c) or (f), as applicable, I may also elect to be excluded from coverage as described in subdivision (c) or (f), as applicable, if I otherwise meet the criteria for exclusion as described in the first paragraph of this document.

_____ _____
PRINT GENERAL PARTNER'S/ MANAGING MEMBER'S FULL NAME — TITLE

_____ _____
GENERAL PARTNER/MANAGING MEMBER SIGNATURE — DATE

ACCEPTED:

_____
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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Submit Forms to: **Email: policysupport@accidentfund.com**
or
Mail: P.O. Box 40790, Lansing, MI 48901-7990

NER-600 B – CA (ed. 07-18)