## **California Officers/Directors of Cooperative Corporations**

## Waiver of Workers' Compensation Coverage

Entity Name:	
officer or member of the board of directors of the about Cooperative Corporation Law, as set forth in Part 2 (cooperations Code. I also hereby certify that I am cover policy and (ii) a disability insurance policy that is compound Commissioner, to a worker's compensation policy.	(A)(i)), I hereby certify, under penalty of perjury, that I am an ove-named cooperative corporation organized pursuant to the commencing with Section 12200) of Division 3 of Title 1 of the ered by both (i) a health care service plan or a health insurance arable in scope and coverage, as determined by the Insurance is a qualifying officer or director of a cooperative corporation, lers' compensation insurance policy providing coverage to the
	effective upon the date of receipt and acceptance by the insured ove-named entity and shall remain in effect until I provide that
I understand and agree that, by signing this waiver, is coverage under any workers' compensation insurance page 1	f an employment-related injury occurs, I will not be entitled to policy providing coverage to the above-named entity.
PRINT OFFICER'S/DIRECTOR'S FULL NAME	TITLE
OFFICER/DIRECTOR SIGNATURE	DATE

## **NOTES TO INSURED/BROKER:**

- The individual electing exclusion must sign this form. Company representatives may not sign on behalf of the individual.
- Only one individual may be excluded per form. Submit additional forms if needed.
- An appropriate exclusion will be endorsed to your policy upon our receipt and acceptance of a properly completed and signed waiver form.

Please submit signed and completed forms to your broker.