

**GENERAL PARTNERS AND LLC MANAGING MEMBERS – WAIVER OF WORKERS’ COMPENSATION COVERAGE**

**Insured Name:**

**Insurer:**

**Policy Number:**

Pursuant to California Labor Code section 3352(q), 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 and employer’s liability 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 and employer’s liability insurance policy with the above-referenced insurer if an employment-related injury occurs.

\_\_\_\_\_  
PRINT GENERAL PARTNER’S / MANAGING MEMBER’S FULL NAME TITLE

\_\_\_\_\_  
GENERAL PARTNER / MANAGING MEMBER SIGNATURE DATE

ACCEPTED:

\_\_\_\_\_  
INSURER AUTHORIZED REPRESENTATIVE DATE

**NOTE TO EMPLOYER:** Failure to return this form will result in all persons being included and the policy subject to additional premium. 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.

**Submit forms to:** Email to [Prem.audit@meadowbrook.com](mailto:Prem.audit@meadowbrook.com) Fax (877)892-0168 or via USPS to  
Meadowbrook Insurance Group P.O. Box 219183 Kansas City MO. 64121