



WORKERS' COMPENSATION EXCLUSION OF COVERAGE

Please type or print.

It is understood and agreed that I (we) whose signature(s) appear below wish to be excluded from all benefits normally provided on the Workers' Compensation and Employers' Liability policy. This is to apply to the present, as well as any succeeding policies.

Named Insured	Date
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Corporate Officers

Name	Signature	Title
Name	Signature	Title
Name	Signature	Title
Name	Signature	Title
Name	Signature	Title

Sole Proprietor/Partners/LLC

Name	Signature	Select one <input type="checkbox"/> Individual <input type="checkbox"/> Partner <input type="checkbox"/> LLC
Name	Signature	Select one <input type="checkbox"/> Individual <input type="checkbox"/> Partner <input type="checkbox"/> LLC
Name	Signature	Select one <input type="checkbox"/> Individual <input type="checkbox"/> Partner <input type="checkbox"/> LLC
Name	Signature	Select one <input type="checkbox"/> Individual <input type="checkbox"/> Partner <input type="checkbox"/> LLC

Note: Certain states require notice of exclusions of coverage. Check with your producer to be certain that you are in compliance with your state's laws.