



**IMPORTANT NOTICE REGARDING INDIVIDUALS EXCLUDED FROM YOUR POLICY**  
**IMMEDIATE RESPONSE REQUIRED**

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**Re: Notice of Change in Law Effective 1/1/17 due to AB 2883**  
**Corporate Officer & Director Exclusions on your STATE FUND WC policy**

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Dear Policyholder:

There has been a significant change in California workers' compensation law that takes effect January 1, 2017 and may affect the insurance coverage and premiums on your current and future workers' compensation policies. *Please read this letter carefully and follow the instructions outlined to ensure your policy is compliant with the new law.*

AB 2883 was signed into law August 26, 2016 and amends Labor Code sections 3351 and 3352, changing the definition of "employee" and the eligibility criteria to elect exclusion from workers' compensation coverage. Beginning January 1, 2017 all workers' compensation insurance policies will be required to cover certain officers and directors of private or quasi-public corporations, and working members of partnerships and limited liability companies that may have been previously excluded from coverage.

The legal entity of your business is identified as a **corporation** on your policy with State Fund. Under AB 2883 the following changes become effective for all corporations on 1/1/2017 regardless of the inception date of the policy:

1. Only Corporate Officers or members of Board of Directors who own **15% or more** of the issued and outstanding stock of a corporation may elect to be excluded from coverage.
2. Each Corporate Officer and Director who owns 15% or more of the corporation's stock and wishes to be excluded from coverage must complete and sign a new **Waiver Form** attesting to his/her eligibility to be excluded, under penalty of perjury.
3. The requirement that 100% of the corporate stock must be owned by Corporate Officers and Directors (in order for a Corporate Officer or Director to elect exclusion from workers' compensation coverage) has been eliminated from the Labor Code.

To ensure that your workers' compensation insurance policy complies with the new law, State Fund must confirm which of your Officers and Directors are eligible to elect exclusion, and we must obtain new signed Waiver Forms for them. If previously-excluded individuals are no longer eligible for exclusion under the new law, State Fund is required to add these individuals to your policy as of 1/1/2017 (and on future policies), as well as, add their payroll to the



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calculation of your estimated annual premium (subject to the Workers' Compensation Insurance Rating Bureau's minimum/maximum payroll rules, where applicable).

**Our objective is to help you achieve compliance with this new law.** In order for you to continue to exclude qualifying individuals from your WC policy, you must complete the information requested in this notice and return it to State Fund. In compliance with AB 2883, State Fund will automatically expire the following endorsements as of 12/31/2016:

- Endorsement 1600 – Corporate Officers and Directors Excluded
- Endorsement 1700 – General Partners Excluded
- Endorsement 1901 – Limited Liability Company Managers-Members Excluded

New endorsements will be added to your policy effective 1/1/2017, if you provide the necessary documentation as outlined in this notice.

**Instructions:**

Please follow the AB 2883 Compliance Guide on page 3 of this notice and return the information requested including all signed forms, as appropriate (pages 4 & 5). Please note that separate signed forms will be required for each individual, according to their exclusion or inclusion.

**Response Options:**

1. By email: scan and email your completed package to State Fund at [WaiverForm@scif.com](mailto:WaiverForm@scif.com) as soon as possible, but no later than **December 31, 2016**.
2. If you prefer to mail via USPS: please mail your completed package to **State Fund – Attn: Waiver Response Team, PO Box 969000, Vacaville, CA 95696-9000**. Please ensure receipt by State Fund no later than **December 31, 2016**.

If the signed waivers are not returned by the December 31<sup>st</sup>, 2016 deadline, State Fund will be required under the new law to include all Corporate Officers and Directors on the policy, which will increase your premium.

Thank you for your attention to this important information. We appreciate your business and are committed to working with our policyholders to comply with this new law.

If you have questions, please contact your Broker or contact a State Fund Representative toll free at **888-STATEFUND (888-782-8338)**.

Sincerely,

STATE COMPENSATION INSURANCE FUND



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**Step 1 – List all Corporate Officers and Directors with Ownership**

Please list the first and last name, corporate title and percentage of stock owned for all of your Corporate Officers and Directors.

First and Last Name of Corporate Officer/Director    Corporate Title    % of Stock owned

- 1.
- 2.
- 3.
- 4.

*-Please provide additional page, if needed-*

**Step 2 – Qualifying Individuals – Complete and Sign the Waiver Form**

Corporate Officers or members of Board of Directors who own **15%** or more of the corporate stock and who wish to be excluded from coverage under the above-referenced policy must sign a written waiver of workers' compensation benefits under penalty of perjury certifying that he or she is a qualifying Corporate Officer or Director. A copy of the **Waiver Form** is attached. A separate waiver form must be completed and signed by each qualifying individual who wishes to elect exclusion from the policy. The Waiver Form(s) must be signed by the individual to be excluded and not by an employer or employer representative. The exclusion(s) will be effective as of 1/1/2017, or as of the date we receive and accept properly completed and signed waiver forms (if received after 1/1/2017). If you provide the necessary signed waivers by 12/31/2016, your policy will not reflect a premium charge for qualifying individuals who elect to be excluded.

**Step 3 – Corporate Officers and Directors Not Eligible To Be Excluded**

Each Corporate Officer and Director who needs to be included under the policy (but is currently excluded) will need to complete a **Coverage Questionnaire for Included Individuals** form. A copy of this form is attached. Your policy will reflect a premium charge for these individuals.

**Thank you for attention to this important matter.**

**Please return the necessary documents (including this completed page) as soon as possible – but no later than 12/31/16. If you are returning multiple signed forms, please return them together so that they may be processed efficiently.**



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**CORPORATE OFFICERS/DIRECTORS –**  
**WAIVER OF WORKERS' COMPENSATION COVERAGE**

Insured (Policyholder) Name: \_\_\_\_\_  
(PRINT FULL NAME OF EMPLOYER / POLICYHOLDER)

Policy No.: \_\_\_\_\_

Insurer: **State Compensation Insurance Fund (State Fund)**

Pursuant to California Labor Code section 3352(p), I hereby certify, under penalty of perjury, that I am a qualifying Officer or Director of the above-named insured, which is a quasi-public or private corporation, and that I own at least 15 percent (15%) of the issued and outstanding stock of the above-named insured corporation. As a qualifying Officer or Director, I elect to be excluded from the corporation's workers' compensation insurance policy with State Fund. I understand and agree that this written waiver will be effective upon the date of receipt and acceptance by State Fund, and it shall remain in effect until State Fund receives and accepts a written withdrawal of this waiver from me. 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 State Fund under any circumstances, including if an employment-related injury occurs.

\_\_\_\_\_  
PRINT FULL NAME OF CORPORATE OFFICER / DIRECTOR TO BE EXCLUDED      TITLE      OWNERSHIP %

\_\_\_\_\_  
SIGNATURE OF CORPORATE OFFICER / DIRECTOR TO BE EXCLUDED      DATE

NOTE TO EMPLOYER: The person electing exclusion from the policy must sign this form. Company representatives of the employer may not sign on behalf of the individual being excluded. One excluded individual per form. If this form is properly completed and signed, the exclusion of the qualifying individual will be endorsed to the policy by State Fund effective 1/1/2017, or as of the date of receipt and acceptance by State Fund (if received after 1/1/2017).

STATE FUND INTERNAL USE ONLY: Waiver Form (CORPORATE OFFICERS/DIRECTORS) – Ed. 10/2016  
DATE RECEIVED AND ACCEPTED: \_\_\_\_\_ NOTE: \_\_\_\_\_



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\_\_\_\_\_

**Coverage Questionnaire for Included Individuals**

**Corporate Officers / Directors / Partners / LLC Managing-Members**

Please complete this form for each Corporate Officer, Director, General Partner or Managing-Member who is not eligible to elect exclusion from your WC policy (or is eligible to elect exclusion but has elected to be included on the WC policy). One form per individual. Failure to complete this questionnaire with sufficient detail may impact our ability to accurately update your policy.

Corporate Officer / Director / Partner / Managing-Member \_\_\_\_\_  
(Name of Person)

Policy # \_\_\_\_\_  
(Title of Person)

Employer Name \_\_\_\_\_  
(Name of Entity) (Legal Entity Type)

List the **annual compensation (salary and bonus)** of above Officer / Director / Partner / Managing-Member \_\_\_\_\_

**PLEASE DESCRIBE** job duties of the Corporate Officer, Director or Partner or LLC Managing-Member, including physical operations performed, daily routines, and work locations visited. Please note: "administration" or "management" are insufficient job duty descriptions.

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*(please add additional pages to explain, if necessary)*

**If supervision is performed by this individual, what operations are being supervised?**

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\_\_\_\_\_

**If sales are a job duty by this individual, estimate percentage of inside and outside sales work.**

\_\_\_\_\_

Signature of Corporate Officer/Director/Partner/Managing-Member Title Date



**IMPORTANT NOTICE REGARDING INDIVIDUALS EXCLUDED FROM YOUR POLICY**  
**IMMEDIATE RESPONSE REQUIRED**

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**Re: Notice of Change in Law Effective 1/1/17 due to AB 2883**  
**Individuals Excluded on your STATE FUND WC policy**

Dear Policyholder:

There has been a significant change in California Workers' Compensation Law that takes effect January 1, 2017 and may affect the coverage and premiums on your current and future workers' compensation policies. *So please read this letter carefully and follow the instructions outlined to ensure your policy is compliant with the new law.*

AB 2883 was signed into law August 26, 2016 and amends Labor Code sections 3351 and 3352 changing the definition of "employee" and the eligibility criteria to elect exclusion from workers' compensation coverage. Beginning January 1, 2017 all workers' compensation insurance policies will be required to cover certain officers and directors of private or quasi-public corporations and working members of partnerships and limited liability companies that may have been previously excluded from coverage.

The legal entity of your business is identified as **multiple entity** (two or more combinable legal entities) on your policy with State Fund. If any of your entities are a corporation, partnership or a limited liability company (LLC), please read this notice carefully. Under AB 2883 the following changes become effective on 1/1/2017 regardless of the inception date of the policy:

1. Only Corporate Officers or members of Board of Directors who own **15% or more** of the issued and outstanding stock of a corporation may elect to be excluded from coverage.
2. Each Corporate Officer and Director who owns 15% or more of the corporation's stock and wishes to be excluded from coverage must complete and sign a new **Waiver Form** attesting to his/her eligibility to be excluded, under penalty of perjury.
3. The requirement that 100% of the corporate stock must be owned by Corporate Officers and Directors (in order for a Corporate Officer and Director to elect exclusion from workers' compensation coverage) has been eliminated from the Labor Code.
4. In order for a General Partner of a partnership or a Managing Member of a LLC to be excluded from coverage, each General Partner and each Managing Member must sign a new **Waiver Form** attesting to his/her eligibility to be excluded, under penalty of perjury.

To ensure that your workers' compensation insurance policy complies with the new law, State Fund must confirm which of your excluded individuals are eligible to elect exclusion by obtaining new signed Waiver Forms for them. If previously-excluded individuals are no longer eligible for



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exclusion under the new law, State Fund is required to add these individuals to your policy as of 1/1/2017 (and on future policies), as well as, add their payroll to the calculation of your estimated annual premium (subject to the Workers' Compensation Insurance Rating Bureau's minimum / maximum payroll rules, where applicable).

**Our objective is to help you achieve compliance with this new law.** In order for you to continue to exclude qualifying individuals from your WC policy, you must complete the information requested in this notice and return it to State Fund. In compliance with AB 2883, State Fund will automatically expire the following endorsements as of 12/31/2016:

- Endorsement 1600 – Corporate Officers and Directors Excluded
- Endorsement 1700 – General Partners Excluded
- Endorsement 1901 – Limited Liability Company Managers-Members Excluded

New endorsements will be added to your policy effective 1/1/2017, if you provide the necessary documentation as outlined in this notice.

**Instructions:**

Please follow the AB 2883 Compliance Guide on pages 3 and 4 of this notice and return the information requested including all signed forms, as appropriate (pages 5 – 8). Please note that separate signed forms will be required for each individual, according to their exclusion or inclusion, and according to which legal entity type they fall under.

**Response Options:**

1. By e-mail: scan and email your completed package to State Fund at: [WaiverForm@scif.com](mailto:WaiverForm@scif.com) as soon as possible, but no later than **December 31, 2016**.
2. If you prefer to mail via USPS: please mail your completed package to: **State Fund – Attn: Waiver Response Team, PO Box 969000, Vacaville, CA 95696-9000**. Please ensure receipt by State Fund no later than **December 31, 2016**.

If the waivers are not returned by the December 31<sup>st</sup>, 2016 deadline, State Fund will be required under the new law to include all Corporate Officers and Directors, General Partners, and Managing Members (as applicable) on the policy, which will increase your premium.

Thank you for your attention to this important information. We appreciate your business and are committed to working with our policyholders to comply with this new law.

If you have questions, please contact your Broker or contact a State Fund Representative toll free at **888-STATEFUND (888-782-8338)**.

Sincerely,

STATE COMPENSATION INSURANCE FUND



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**Step 1 – List all Corporate Officers / Directors / General Partners / Managing Members**

Please provide the following information (separate lists) for each legal entity covered on your policy, in order for us to confirm which individuals qualify to be excluded.

- For each corporation – please list the legal name of the corporation, and please provide breakdown of ownership. Please list each Corporate Officer’s/Director’s Full Name, Corporate Title and percentage of ownership.
- For each partnership – please list the legal name of the partnership, and please list each General Partner’s Full Name. Please indicate “General Partner” next to name of each individual who is a General Partner.
- For each LLC – please list the legal name of the LLC, and list each Managing Members Full Name. Please indicate “Managing Member” next to name of each individual who is a Managing Member.

*-Please provide on separate pages, as needed-*

**Step 2 – Qualifying Individuals – Complete and Sign the Waiver Form**

**Corporate Officers or members of Board of Directors** who own 15% or more of the corporate stock and who wish to be excluded from coverage under the above-referenced policy must sign a written **Waiver** of workers’ compensation benefits under penalty of perjury certifying that he or she is a qualifying Corporate Officer or Director.\*\*

**General Partners** of a partnership who wish to be excluded from coverage under the State Fund policy must sign a **Waiver** of workers’ compensation benefits under penalty of perjury certifying he/she is a qualifying General Partner.\*\*

**Managing Members** of a LLC who wish to be excluded from coverage under the State policy must sign a **Waiver** of workers’ compensation benefits under penalty of perjury certifying he/she is a qualifying Managing Member.\*\*

**\*\*Important Exception** – An individual (Officer, Director, General Partner, Managing Member) cannot be excluded (for one legal entity) and included (for another legal entity) on a single policy. Therefore, if an individual does **not** qualify to be excluded on any one of the entities, then that individual must be **included** for coverage on the policy. If you have this circumstance for an individual who is currently excluded from your policy, please complete the attached **Coverage Questionnaire for Included Individuals**.





Copies of the new **Waiver Forms (for each legal entity type)** are attached. The Waiver Form(s) must be signed by the individual to be excluded and not by an employer or employer representative. Each individual who is eligible for exclusion in 2017 must complete and sign a Waiver Form. The exclusion(s) will be effective as of 1/1/2017, or as of the date we receive and accept properly completed and signed waiver forms (if received after 1/1/2017). If you provide the necessary signed waivers by 12/31/2016, your policy will not reflect a premium charge for qualifying individuals who elect to be excluded.

**Step 3 – Currently Excluded Individuals Who Are Ineligible to Elect Exclusion**

If you have a corporation, each Corporate Officer and Director who needs to be included under the policy (but is currently excluded) will need to complete a **Coverage Questionnaire for Included Individuals** form. A copy of this form is attached. Your policy will reflect a premium charge for these individuals.

If you have a partnership or LLC, each General Partner or Managing Member who needs to be included under the policy (but is currently excluded) will need to complete a **Coverage Questionnaire for Included Individuals** form. A copy of this form is attached. Your policy will reflect a premium charge for these individuals.

**Thank you for attention to this important matter.**

**Please return the necessary documents (including the lists requested on page 3) as soon as possible – but no later than 12/31/16. If you are returning multiple signed forms, please return them together so that they may be processed efficiently.**



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**CORPORATE OFFICERS / DIRECTORS –**

**W A I V E R O F W O R K E R S ' C O M P E N S A T I O N C O V E R A G E**

Insured (Policyholder) Name: \_\_\_\_\_  
(PRINT FULL NAME OF EMPLOYER / POLICYHOLDER)

Policy No.: \_\_\_\_\_

Insurer: **State Compensation Insurance Fund (State Fund)**

Pursuant to California Labor Code section 3352(p), I hereby certify, under penalty of perjury, that I am a qualifying Officer or Director of the above-named insured, which is a quasi-public or private corporation, and that I own at least 15 percent (15%) of the issued and outstanding stock of the above-named insured corporation. As a qualifying Officer or Director, I elect to be excluded from the corporation's workers' compensation insurance policy with State Fund. I understand and agree that this written waiver will be effective upon the date of receipt and acceptance by State Fund, and it shall remain in effect until State Fund receives and accepts a written withdrawal of this waiver from me. 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 State Fund under any circumstances, including if an employment-related injury occurs.

_____	_____	_____
<b>PRINT FULL NAME OF CORPORATE OFFICER / DIRECTOR TO BE EXCLUDED</b>	<b>TITLE</b>	<b>OWNERSHIP %</b>

_____	_____
<b>SIGNATURE OF CORPORATE OFFICER / DIRECTOR TO BE EXCLUDED</b>	<b>DATE</b>

NOTE TO EMPLOYER: The person electing exclusion from the policy must sign this form. Company representatives of the employer may not sign on behalf of the individual being excluded. One excluded individual per form. If this form is properly completed and signed, the exclusion of the qualifying individual will be endorsed to the policy by State Fund effective 1/1/2017, or as of the date of receipt and acceptance by State Fund (if received after 1/1/2017).

<b>STATE FUND INTERNAL USE ONLY: Waiver Form (CORPORATE OFFICERS/DIRECTORS) – Ed. 10/2016</b> <b>DATE RECEIVED AND ACCEPTED: _____ NOTE: _____</b>
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**GENERAL PARTNERS –**  
**W A I V E R O F W O R K E R S ' C O M P E N S A T I O N C O V E R A G E**

Insured (Policyholder) Name: \_\_\_\_\_  
(PRINT FULL NAME OF EMPLOYER / POLICYHOLDER)

Policy No.: \_\_\_\_\_

Insurer: **State Compensation Insurance Fund (State Fund)**

Pursuant to California Labor Code section 3352(q), I hereby certify, under penalty of perjury, that I am a qualifying General Partner of the above-named insured, which is a partnership. As a qualifying General Partner, I elect to be excluded from the insured's workers' compensation insurance policy with State Compensation Insurance Fund (State Fund). I understand and agree that this written waiver will be effective upon the date of receipt and acceptance by State Fund, and it shall remain in effect until State Fund receives and accepts a written withdrawal of this waiver from me. 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 State Fund under any circumstances, including if an employment-related injury occurs.

\_\_\_\_\_  
PRINT FULL NAME OF GENERAL PARTNER  
TO BE EXCLUDED

\_\_\_\_\_  
TITLE

\_\_\_\_\_  
SIGNATURE OF GENERAL PARTNER  
TO BE EXCLUDED

\_\_\_\_\_  
DATE

NOTE TO EMPLOYER: The person electing exclusion from the policy must sign this form. Company representatives of the employer may not sign on behalf of the individual being excluded. One excluded individual per form. If this form is properly completed and signed, the exclusion of the qualifying individual will be endorsed to the policy by State Fund effective 1/1/2017, or as of the date of receipt and acceptance by State Fund (if received after 1/1/2017).

STATE FUND INTERNAL USE ONLY:	Waiver Form (GENERAL PARTNERS) – Ed. 10/2016
DATE RECEIVED AND ACCEPTED: _____	NOTE: _____



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**LLC MANAGING MEMBERS –**

**W A I V E R O F W O R K E R S ' C O M P E N S A T I O N C O V E R A G E**

Insured (Policyholder) Name: \_\_\_\_\_  
(PRINT FULL NAME OF EMPLOYER / POLICYHOLDER)

Policy No.: \_\_\_\_\_

Insurer: **State Compensation Insurance Fund (State Fund)**

Pursuant to California Labor Code section 3352(q), I hereby certify, under penalty of perjury, that I am a qualifying Managing Member of the above-named insured, which is a limited liability company. As a qualifying Managing Member, I elect to be excluded from the insured's workers' compensation insurance policy with State Compensation Insurance Fund (State Fund). I understand and agree that this written waiver will be effective upon the date of receipt and acceptance by State Fund, and it shall remain in effect until State Fund receives and accepts a written withdrawal of this waiver from me. 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 State Fund under any circumstances, including if an employment-related injury occurs.

\_\_\_\_\_  
PRINT FULL NAME OF LLC MANAGING MEMBER  
TO BE EXCLUDED

\_\_\_\_\_  
TITLE

\_\_\_\_\_  
SIGNATURE OF LLC MANAGING MEMBER  
TO BE EXCLUDED

\_\_\_\_\_  
DATE

NOTE TO EMPLOYER: The person electing exclusion from the policy must sign this form. Company representatives of the employer may not sign on behalf of the individual being excluded. One excluded individual per form. If this form is properly completed and signed, the exclusion of the qualifying individual will be endorsed to the policy by State Fund effective 1/1/2017, or as of the date of receipt and acceptance by State Fund (if received after 1/1/2017).

STATE FUND INTERNAL USE ONLY: Waiver Form (LLC MANAGING MEMBERS) – Ed. 10/2016  
DATE RECEIVED AND ACCEPTED: \_\_\_\_\_ NOTE: \_\_\_\_\_



\_\_\_\_\_  
\_\_\_\_\_

**Coverage Questionnaire for Included Individuals**

**Corporate Officers / Directors / Partners / LLC Managing-Members**

**Please complete this form for each Corporate Officer, Director, General Partner or Managing-Member who is not eligible to elect exclusion from your WC policy (or is eligible to elect exclusion but has elected to be included on the WC policy). One form per individual. Failure to complete this questionnaire with sufficient detail may impact our ability to accurately update your policy.**

Corporate Officer / Director / Partner / Managing-Member \_\_\_\_\_  
(Name of Person)

Policy # \_\_\_\_\_  
(Title of Person)

Employer Name \_\_\_\_\_  
(Name of Entity) (Legal Entity Type)

List the **annual compensation (salary and bonus)** of above Officer / Director / Partner / Managing-Member \_\_\_\_\_

**PLEASE DESCRIBE** job duties of the Corporate Officer, Director or Partner or LLC Managing-Member, including physical operations performed, daily routines, and work locations visited. Please note: "administration" or "management" are insufficient job duty descriptions.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*(please add additional pages to explain, if necessary)*

**If supervision is performed by this individual, what operations are being supervised?**

\_\_\_\_\_  
\_\_\_\_\_

**If sales are a job duty by this individual, estimate percentage of inside and outside sales work.**

\_\_\_\_\_

Signature of Corporate Officer/Director/Partner/Managing-Member Title Date



**IMPORTANT NOTICE REGARDING INDIVIDUALS EXCLUDED FROM YOUR POLICY**  
**IMMEDIATE RESPONSE REQUIRED**

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**Re: Notice of Change in Law Effective 1/1/17 due to AB 2883**  
**Manager-Member Exclusions on your STATE FUND WC policy**

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Dear Policyholder:

There has been a significant change in California Workers' Compensation Law that takes effect January 1, 2017 and may affect the coverage and premiums on your current and future workers' compensation policies. *So please read this letter carefully and follow the instructions outlined to ensure your policy is compliant with the new law.*

AB 2883 was signed into law August 26, 2016 and amends Labor Code sections 3351 and 3352 changing the definition of "employee" and the eligibility criteria to elect exclusion from workers' compensation coverage. Beginning January 1, 2017 all workers' compensation insurance policies will be required to cover certain officers and directors of private or quasi-public corporations and working members of partnerships and limited liability companies that may have been previously excluded from coverage.

The legal entity of your business is identified as a **limited liability company** on your policy with State Fund. Under AB 2883 the following changes become effective for all limited liability companies on 1/1/2017 regardless of the inception date of the policy:

Effective January 1, 2017, in order for a Managing Member of a Limited Liability Company (LLC) to be excluded from the WC policy, the Managing Member must sign a new waiver of workers' compensation benefits, under penalty of perjury. If there is more than one Managing Member of the LLC, each of the Managing Members must sign a separate Waiver Form.

To ensure that your workers' compensation insurance policy complies with the new law, State Fund must confirm which of your Managing Members are eligible to elect exclusion by obtaining new signed Waiver Forms for them. If previously-excluded individuals are no longer eligible for exclusion under the new law, State Fund is required to add these individuals to your policy as of 1/1/2017 (and on future policies), as well as, add their payroll to the calculation of your estimated annual premium (subject to the Workers' Compensation Insurance Rating Bureau's minimum / maximum payroll rules, where applicable).



Page 2

Our objective is to help you achieve compliance with this new law. In order for you to continue to exclude qualifying individuals from your WC policy, you must complete the information requested in this notice and return it to State Fund. In compliance with AB 2883, State Fund will automatically expire the following endorsements as of 12/31/2016:

- Endorsement 1600 – Corporate Officers and Directors Excluded
- Endorsement 1700 – General Partners Excluded
- Endorsement 1901 – Limited Liability Company Managers-Members Excluded

New endorsements will be added to your policy effective 1/1/2017, if you provide the necessary documentation as outlined in this notice.

**Instructions:**

Please follow the AB 2883 Compliance Guide on page 3 of this notice and return the information requested including all signed forms, as appropriate (pages 4 & 5). Please note that separate signed forms will be required for each individual, according to their exclusion or inclusion.

**Response Options:**

1. By e-mail: scan and email your completed package to State Fund at: [WaiverForm@scif.com](mailto:WaiverForm@scif.com) as soon as possible, but no later than **December 31, 2016**.
2. If you prefer to mail via USPS: please mail your completed package to: **State Fund – Attn: Waiver Response Team, PO Box 969000, Vacaville, CA 95696-9000.** Please ensure receipt by State Fund no later than **December 31, 2016**.

If the waivers are not returned by the December 31<sup>st</sup>, 2016 deadline, State Fund will be required under the new law to include all LLC Managing Members on the policy, which will increase your premium.

Thank you for your attention to this important information. We appreciate your business and are committed to working with our policyholders to comply with this new law.

If you have questions, please contact your Broker or contact a State Fund Representative toll free at **888-STATEFUND (888-782-8338)**.

Sincerely,

STATE COMPENSATION INSURANCE FUND



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**Step 1 – List of all Managing–Members of your LLC**

In the space below, please list each **Managing-Member** of your LLC:

First and Last Name of Managing Members

- 1.
- 2.
- 3.
- 4.

*-Please provide additional page, if needed-*

**Step 2 – Qualifying Individuals - Complete and Sign the Waiver Form**

All Managing Members of the LLC who wish to be excluded from coverage under the State Fund policy must sign a new written **Waiver** of workers' compensation benefits, under penalty of perjury certifying that he or she is a qualifying Managing Member. A copy of the required **Waiver Form** is attached. Please make additional copies of the Waiver Form as needed.

Each Waiver Form must be signed by the individual to be excluded and not by an employer or employer representative. The exclusion(s) will be effective as of 1/1/2017, or as of the date we receive and accept properly completed and signed waiver forms (if received after 1/1/2017). If you provide the necessary signed waivers by 12/31/2016, your policy will not reflect a premium charge for qualifying individuals who elect to be excluded.

**Step 3 – Currently Excluded Individuals Who Are Ineligible to Elect Exclusion**

Each Managing Member who needs to be included under the policy (but is currently excluded) will need to complete a **Coverage Questionnaire for Included Individuals** form. A copy of this form is attached. Your policy will reflect a premium charge for these individuals.

**Thank you for attention to this important matter.**

**Please return the necessary documents (including this completed page) as soon as possible – but no later than 12/31/16. If you are returning multiple signed forms, please return them together so that they may be processed efficiently.**





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**LLC MANAGING MEMBERS –**

**W A I V E R O F W O R K E R S ' C O M P E N S A T I O N C O V E R A G E**

Insured (Policyholder) Name: \_\_\_\_\_  
(PRINT FULL NAME OF EMPLOYER / POLICYHOLDER)

Policy No.: \_\_\_\_\_

Insurer: **State Compensation Insurance Fund (State Fund)**

Pursuant to California Labor Code section 3352(q), I hereby certify, under penalty of perjury, that I am a qualifying Managing Member of the above-named insured, which is a limited liability company. As a qualifying Managing Member, I elect to be excluded from the insured's workers' compensation insurance policy with State Compensation Insurance Fund (State Fund). I understand and agree that this written waiver will be effective upon the date of receipt and acceptance by State Fund, and it shall remain in effect until State Fund receives and accepts a written withdrawal of this waiver from me. 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 State Fund under any circumstances, including if an employment-related injury occurs.

\_\_\_\_\_  
PRINT FULL NAME OF LLC MANAGING MEMBER  
TO BE EXCLUDED

\_\_\_\_\_  
TITLE

\_\_\_\_\_  
SIGNATURE OF LLC MANAGING MEMBER  
TO BE EXCLUDED

\_\_\_\_\_  
DATE

NOTE TO EMPLOYER: The person electing exclusion from the policy must sign this form. Company representatives of the employer may not sign on behalf of the individual being excluded. One excluded individual per form. If this form is properly completed and signed, the exclusion of the qualifying individual will be endorsed to the policy by State Fund effective 1/1/2017, or as of the date of receipt and acceptance by State Fund (if received after 1/1/2017).

STATE FUND INTERNAL USE ONLY:	Waiver Form (LLC MANAGING MEMBERS) – Ed. 10/2016
DATE RECEIVED AND ACCEPTED: _____	NOTE: _____



\_\_\_\_\_  
\_\_\_\_\_

**Coverage Questionnaire for Included Individuals**

**Corporate Officers / Directors / Partners / LLC Managing-Members**

**Please complete this form for each Corporate Officer, Director, General Partner or Managing-Member who is not eligible to elect exclusion from your WC policy (or is eligible to elect exclusion but has elected to be included on the WC policy). One form per individual. Failure to complete this questionnaire with sufficient detail may impact our ability to accurately update your policy.**

Corporate Officer / Director / Partner / Managing-Member \_\_\_\_\_  
(Name of Person)

Policy # \_\_\_\_\_  
(Title of Person)

Employer Name \_\_\_\_\_  
(Name of Entity) (Legal Entity Type)

List the **annual compensation (salary and bonus)** of above Officer / Director / Partner / Managing-Member \_\_\_\_\_

**PLEASE DESCRIBE** job duties of the Corporate Officer, Director or Partner or LLC Managing-Member, including physical operations performed, daily routines, and work locations visited. **Please note: "administration" or "management" are insufficient job duty descriptions.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*(please add additional pages to explain, if necessary)*

**If supervision is performed by this individual, what operations are being supervised?**

\_\_\_\_\_  
\_\_\_\_\_

**If sales are a job duty by this individual, estimate percentage of inside and outside sales work.**

\_\_\_\_\_

Signature of Corporate Officer/Director/Partner/Managing-Member Title Date



**IMPORTANT NOTICE REGARDING INDIVIDUALS EXCLUDED FROM YOUR POLICY  
IMMEDIATE RESPONSE REQUIRED**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Re: Notice of Change in Law Effective 1/1/17 due to AB 2883  
General Partner Exclusions on your STATE FUND WC policy**

\_\_\_\_\_

Dear Policyholder:

There has been a significant change in California Workers' Compensation Law that takes effect January 1, 2017 and may affect the coverage and premiums on your current and future workers' compensation policies. *So please read this letter carefully and follow the instructions outlined to ensure your policy is compliant with the new law.*

AB 2883 was signed into law August 26, 2016 and amends Labor Code sections 3351 and 3352 changing the definition of "employee" and the eligibility criteria to elect exclusion from workers' compensation coverage. Beginning January 1, 2017 all workers' compensation insurance policies will be required to cover certain officers and directors of private or quasi-public corporations and working members of partnerships and limited liability companies that may have been previously excluded from coverage.

The legal entity of your business is identified as a **partnership** on your policy with State Fund. Under AB 2883 the following changes become effective for all partnerships on 1/1/2017 regardless of the inception date of the policy:

Effective January 1, 2017, in order for a General Partner of a partnership to be excluded from the WC policy, the General Partner must sign a new Waiver of workers' compensation benefits, under penalty of perjury. Each General Partner who is electing exclusion from WC coverage must sign a separate Waiver Form.

To ensure that your workers' compensation insurance policy complies with the new law, State Fund must confirm which of your General Partners are eligible to elect exclusion by obtaining new signed Waiver Forms for them. If previously-excluded individuals are no longer eligible for exclusion under the new law, State Fund is required to add these individuals to your policy as of 1/1/2017 (and on future policies), as well as, add their payroll to the calculation of your estimated annual premium (subject to the Workers' Compensation Insurance Rating Bureau's minimum / maximum payroll rules, where applicable).



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**Our objective is to help you achieve compliance with this new law.** In order for you to continue to exclude qualifying individuals from your WC policy, you must complete the information requested in this notice and return it to State Fund. In compliance with AB 2883, State Fund will automatically expire the following endorsements as of 12/31/2016:

- Endorsement 1600 – Corporate Officers and Directors Excluded
- Endorsement 1700 – General Partners Excluded
- Endorsement 1901 – Limited Liability Company Managers-Members Excluded

New endorsements will be added to your policy effective 1/1/2017, if you provide the necessary documentation as outlined in this notice.

**Instructions:**

Please follow the AB 2883 Compliance Guide on page 3 of this notice and return the information requested including all signed forms, as appropriate (pages 4 & 5). Please note that separate signed forms will be required for each individual, according to their exclusion or inclusion.

**Response Options:**

1. By e-mail: scan and email your completed package to State Fund at: [WaiverForm@scif.com](mailto:WaiverForm@scif.com) as soon as possible, but no later than **December 31, 2016**.
2. If you prefer to mail via USPS: please mail your completed package to: **State Fund – Attn: Waiver Response Team, PO Box 969000, Vacaville, CA 95696-9000.** Please ensure receipt by State Fund no later than **December 31, 2016**.

If the waivers are not returned by the December 31<sup>st</sup>, 2016 deadline, State Fund will be required under the new law to include all general partners on the policy, which will increase your premium.

Thank you for your attention to this important information. We appreciate your business and are committed to working with our policyholders to comply with this new law.

If you have questions, please contact your Broker or contact a State Fund Representative toll free at **888-STATEFUND (888-782-8338)**.

Sincerely,

STATE COMPENSATION INSURANCE FUND



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**Step 1 – List of All General Partners of your Partnership**

In the space below, please list each **General Partner** of your partnership:

First and Last Name of General Partners

- 1.
- 2.
- 3.
- 4.

*-Please provide additional page, if needed-*

**Step 2 – Qualifying Individuals – Complete and Sign the Waiver Form**

Each General Partner of the partnership who wishes to be excluded from coverage under the State Fund policy must sign a new written **Waiver** of workers' compensation benefits under penalty of perjury certifying that he or she is a qualifying General Partner. A copy of the required **Waiver Form** is attached. Please make additional copies of the Waiver Form as needed.

Each Waiver Form must be signed by the individual to be excluded and not by an employer or employer representative. The exclusion of the General Partner(s) will be effective as of 1/1/2017, or as of the date we receive and accept properly completed and signed Waiver Forms (if received after 1/1/2017). If you provide the necessary signed waivers by 12/31/2016, your policy will not reflect a premium charge for qualifying individuals who elect to be excluded.

**Step 3 – Currently Excluded Individuals Who Are Ineligible to Elect Exclusion**

Each General Partner who needs to be included under the policy (but is currently excluded) will need to complete a **Coverage Questionnaire for Included Individuals** form. A copy of this form is attached. Your policy will reflect a premium charge for these individuals.

**Thank you for attention to this important matter.**

**Please return the necessary documents (including this completed page) as soon as possible – but no later than 12/31/16. If you are returning multiple signed forms, please return them together so that they may be processed efficiently.**



\_\_\_\_\_  
\_\_\_\_\_

**GENERAL PARTNERS –**  
**W A I V E R O F W O R K E R S ' C O M P E N S A T I O N C O V E R A G E**

Insured (Policyholder) Name: \_\_\_\_\_  
(PRINT FULL NAME OF EMPLOYER / POLICYHOLDER)

Policy No.: \_\_\_\_\_

Insurer: **State Compensation Insurance Fund (State Fund)**

Pursuant to California Labor Code section 3352(q), I hereby certify, under penalty of perjury, that I am a qualifying General Partner of the above-named insured, which is a partnership. As a qualifying General Partner, I elect to be excluded from the insured's workers' compensation insurance policy with State Compensation Insurance Fund (State Fund). I understand and agree that this written waiver will be effective upon the date of receipt and acceptance by State Fund, and it shall remain in effect until State Fund receives and accepts a written withdrawal of this waiver from me. 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 State Fund under any circumstances, including if an employment-related injury occurs.

\_\_\_\_\_  
**PRINT FULL NAME OF GENERAL PARTNER  
TO BE EXCLUDED**

\_\_\_\_\_  
**TITLE**

\_\_\_\_\_  
**SIGNATURE OF GENERAL PARTNER  
TO BE EXCLUDED**

\_\_\_\_\_  
**DATE**

NOTE TO EMPLOYER: The person electing exclusion from the policy must sign this form. Company representatives of the employer may not sign on behalf of the individual being excluded. One excluded individual per form. If this form is properly completed and signed, the exclusion of the qualifying individual will be endorsed to the policy by State Fund effective 1/1/2017, or as of the date of receipt and acceptance by State Fund (if received after 1/1/2017).

**STATE FUND INTERNAL USE ONLY:      Waiver Form (GENERAL PARTNERS) – Ed. 10/2016**  
**DATE RECEIVED AND ACCEPTED: \_\_\_\_\_      NOTE: \_\_\_\_\_**



\_\_\_\_\_  
\_\_\_\_\_

**Coverage Questionnaire for Included Individuals**

**Corporate Officers / Directors / Partners / LLC Managing-Members**

**Please complete this form for each Corporate Officer, Director, General Partner or Managing-Member who is not eligible to elect exclusion from your WC policy (or is eligible to elect exclusion but has elected to be included on the WC policy). One form per individual. Failure to complete this questionnaire with sufficient detail may impact our ability to accurately update your policy.**

Corporate Officer / Director / Partner / Managing-Member \_\_\_\_\_  
(Name of Person)

Policy # \_\_\_\_\_  
(Title of Person)

Employer Name \_\_\_\_\_  
(Name of Entity) (Legal Entity Type)

List the **annual compensation (salary and bonus)** of above Officer / Director / Partner / Managing-Member \_\_\_\_\_

**PLEASE DESCRIBE job duties of the Corporate Officer, Director or Partner or LLC Managing-Member, including physical operations performed, daily routines, and work locations visited. Please note: "administration" or "management" are insufficient job duty descriptions.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*(please add additional pages to explain, if necessary)*

**If supervision is performed by this individual, what operations are being supervised?**

\_\_\_\_\_  
\_\_\_\_\_

**If sales are a job duty by this individual, estimate percentage of inside and outside sales work.**

\_\_\_\_\_

Signature of Corporate Officer/Director/Partner/Managing-Member Title Date