CALIFORNIA

GENERAL PARTNER'S OF PARTNERSHIP-

WAIVER OF WORKERS' COMPENSATION COVERAGE

NAME OF COMPANY:

FEIN:

POLICY #:

Berkshire Hathaway GUARD Insurance Company: ☐ AmGUARD ☐ EastGUARD ☐ NorGUARD

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 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 partnerships or the limited liability company's insurer and it shall remain 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 policy with the above-referenced insurer if an employment-related injury occurs.

_____

PRINT GENERAL PARTNER'S FULL NAME TITLE

_____

GENERAL PARTNER SIGNATURE 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 forms if needed.

Submit forms to: Berkshire Hathaway GUARD Insurance Companies
PO Box A-H, Wilkes-Barre, PA 18703-0020

CALIFORNIA

CORPORATE OFFICERS/DIRECTORS-

WAIVER OF WORKERS' COMPENSATION COVERAGE

NAME OF COMPANY:

FEIN:

POLICY #:

Berkshire Hathaway GUARD Insurance Company: ☐ AmGUARD ☐ EastGUARD ☐ NorGUARD

Pursuant to California Labor Code section 3352(p), I_____ hereby certify, under penalty of perjury, that I am an 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 the above-referenced insurer.

I understand and agree that this written waiver will be effective upon the date of receipt and acceptance by the corporation's insurer and it shall remain 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 policy with the above-referenced insurer if an employment-related injury occurs.

_____

PRINT OFFICER'S/DIRECTOR'S FULL NAME TITLE

_____

OFFICER/DIRECTOR SIGNATURE 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 forms if needed.

Submit forms to: Berkshire Hathaway GUARD Insurance Companies
PO Box A-H, Wilkes-Barre, PA 18703-0020

CALIFORNIA

LIMITED LIABILITY COMPANY MANAGING MEMBERS-

WAIVER OF WORKERS' COMPENSATION COVERAGE

NAME OF COMPANY:

FEIN:

POLICY #:

Berkshire Hathaway GUARD Insurance Company: ☐ AmGUARD ☐ EastGUARD ☐ NorGUARD

Pursuant to California Labor Code section 3352(q), I _____ hereby certify, under penalty of perjury, that I am a managing member of the above named insured. As a qualifying managing member of the insured, 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 partnerships or the limited liability company's insurer and it shall remain 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 policy with the above-referenced insurer if an employment-related injury occurs.

_____

PRINT MANAGING MEMBERS FULL NAME TITLE

_____

MANAGING MEMBERS SIGNATURE 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 forms if needed.

Submit forms to: Berkshire Hathaway GUARD Insurance Companies
PO Box A-H, Wilkes-Barre, PA 18703-0020