

# WORKERS' COMPENSATION COVERAGE OPT-OUT FORM

**The following ownership types must complete this form** if they wish to opt out of the Workers' Compensation Requirement:

**Corporations** with no employees other than the four main corporate officers (president, vice president, secretary & treasurer), must complete this form (Part A Only), signed by each of those four main corporate officers.

**Partnership's** with no employees other than the Partner's, must complete this form (Part B Only), signed by each of the Partner's.

**Limited Liability Companies** with no employees other than Managers/Members, must complete this form (Part C Only), signed by each of the Managers/Members.

*(If more space is needed for any Part of this form, please attach a separate sheet, containing the same information)*

## Part A: Corporations Opt-Out

By signing this form, the undersigned reject benefits provided by the Illinois Workers' Compensation Act as well as any Workers' Compensation and Employer's Liability coverage provided by this policy and hereby verifies that the insurance agent is aware of this decision. Only those individuals who sign below will be excluded from coverage.

Name of Corporation \_\_\_\_\_

President Signature \_\_\_\_\_

President Name (please print) \_\_\_\_\_ Date Signed \_\_\_\_\_

Vice President Signature \_\_\_\_\_

Vice President Name (please print) \_\_\_\_\_ Date Signed \_\_\_\_\_

Secretary Signature \_\_\_\_\_

Secretary Name (please print) \_\_\_\_\_ Date Signed \_\_\_\_\_

Treasurer Signature \_\_\_\_\_

Treasurer Name (please print) \_\_\_\_\_ Date Signed \_\_\_\_\_

**(See Reverse Side for Parts B and C of this form)**

**Part B: Partnerships Opt-Out**

By signing this form, the undersigned reject benefits provided by the Illinois Workers' Compensation Act as well as any Workers' Compensation and Employer's Liability coverage provided by this policy and hereby verifies that the insurance agent is aware of this decision. Only those individuals who sign below will be excluded from coverage.

Name of Partnership \_\_\_\_\_

Partner Signature \_\_\_\_\_

Partner Name (please print) \_\_\_\_\_ Date Signed \_\_\_\_\_

Partner Signature \_\_\_\_\_

Partner Name (please print) \_\_\_\_\_ Date Signed \_\_\_\_\_

Partner Signature \_\_\_\_\_

Partner Name (please print) \_\_\_\_\_ Date Signed \_\_\_\_\_

Partner Signature \_\_\_\_\_

Partner Name (please print) \_\_\_\_\_ Date Signed \_\_\_\_\_

**Part C: Limited Liability Companies Opt-Out**

By signing this form, the undersigned reject benefits provided by the Illinois Workers' Compensation Act as well as any Workers' Compensation and Employer's Liability coverage provided by this policy and hereby verifies that the insurance agent is aware of this decision. Only those individuals who sign below will be excluded from coverage.

Name of Limited Liability Company \_\_\_\_\_

Manager/Member Signature \_\_\_\_\_

Manager/Member Name (please print) \_\_\_\_\_ Date Signed \_\_\_\_\_

Manager/Member Signature \_\_\_\_\_

Manager/Member Name (please print) \_\_\_\_\_ Date Signed \_\_\_\_\_

Manager/Member Signature \_\_\_\_\_

Manager/Member Name (please print) \_\_\_\_\_ Date Signed \_\_\_\_\_

Manager/Member Signature \_\_\_\_\_

Manager/Member Name (please print) \_\_\_\_\_ Date Signed \_\_\_\_\_