



OWNER/OFFICER EXCLUSION FORM (ARKANSAS)

Named Insured: _____

Policy Number (if policy has been issued): _____

Sole proprietors, partners in a partnership, executive officers of a corporation, and members of a limited liability company will be included for coverage unless coverage is rejected. Each sole proprietor, partner, corporate officer, or member of a limited liability company wishing to be excluded from coverage under the Workers' Compensation Act in accordance with Arkansas Code Section 11-9-108 must sign the following and affix their title.

Effective immediately, this form applies to all policies written through Stonetrust Commercial Insurance Company unless rescinded in writing by the sole proprietor, partner, corporate officer, or member of a limited liability company. It must be signed by each individual seeking to be excluded under the policy.

I attest that: I am a sole proprietor, partner, corporate officer, or member of _____

(Named Insured, Corporation, or LLC)

By signing below, I agree this election shall apply but is not limited to all trades, businesses or occupations conducted by the insured's proprietorships, partnerships, corporations, or LLCs.

Signature of Sole Proprietor, Partner, Officer, or Member of LLC Date
Social Security #: _____ % of Ownership: _____
Printed Name: _____ Title: _____

Signature of Sole Proprietor, Partner, Officer, or Member of LLC Date
Social Security #: _____ % of Ownership: _____
Printed Name: _____ Title: _____

Signature of Sole Proprietor, Partner, Officer, or Member of LLC Date
Social Security #: _____ % of Ownership: _____
Printed Name: _____ Title: _____

Signature of Sole Proprietor, Partner, Officer, or Member of LLC Date
Social Security #: _____ % of Ownership: _____
Printed Name: _____ Title: _____

If you have additional officers or partners to be excluded, please use additional forms. For more information on this exclusion, contact your underwriter at (800) 311-0997.