



OWNER/OFFICER EXCLUSION FORM

Named Insured: \_\_\_\_\_

Policy Number (if policy has been issued): \_\_\_\_\_

In accordance with Louisiana Revised Statutes, Title 23, Section 1035, I (we) hereby elect to exclude myself (ourselves) from coverage under the captioned policy and not subject to the provisions of the Louisiana Workers' Compensation Act while employed with the above named insured.

Effective immediately, this form applies to all policies written through Stonetrust Commercial Insurance Company unless rescinded in writing by the executive officer, partner or sole proprietor.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

I attest that:

I am a bona fide president, vice president, secretary or treasurer of \_\_\_\_\_

(Named Insured or Corporation)

who owns not less than ten percent of the stock therein, or

- I am a partner in the above named insured business
I am a sole proprietor in the above named business

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

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

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

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

Signature of Partner, Officer or Sole Proprietor 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.