

Policy Name:			
Policy Number:	Effective Date:		
(Not for use in Louisiana)			
ACCEPTANCE OF SOLE PROPRIETORS, PARTNERS, OFFICERS AND OTHERS COVERAGE			
LUBA requires that any Sole Proprietor, Partner, Executive Officer of a Corporation or Member of an LLC, requesting coverage under the laws of the applicable Workersø Compensation Statute state their intention in writing. EACH SUCH SOLE PROPRIETOR, PARTNER, EXECUTIVE OFFICER OF A CORPORATION OR MEMBER OF AN LLC MUST SIGN THIS FORM FOR ACCEPTANCE OF COVERAGE.			
ACCEPTANCE			
I, the undersigned do hereby agree to pay the prescribed premium in exchange for workersø compensation coverage through LUBA Casualty Insurance Company.			
Last Name, First Name	% of ownership	Title	Class code
Signature		Date	Payroll \$
Last Name, First Name	% of ownership	Title	Class code
Signature		Date	Payroll \$
Last Name, First Name	% of ownership	Title	Class code
Signature		Date	Payroll \$

The above election to **accept** workersø compensation coverage will be effective on the inception date of the policy written by LUBA Casualty Insurance Company and will remain in effect for the duration of the policy term and each subsequent renewal unless a new form signed by owner/officer to rescind election is received. Forms received, signed by owners/officers, to rescind election mid term will be effective the date the signed form is received.

Miscellaneous values for officers, partners, and sole proprietor payroll limitations apply.