PIE INSURANCE

OWNER/OFFICER/AFFILIATE WORKERS COMPENSATION REJECTION/EXCLUSION/INCLUSION FORM

Pursuant to State Worker's Compensation Law

Depending on the state your business resides in, an Officer, Partner, Member, manager, Sole Proprietor or other individual may be required/permitted to elect or reject workers compensation coverage. This document provides record of your decision as your state has not provided a specific form for this purpose. The coverage indicated below will be applied to all subsequent renewal policies until Pie Insurance has been notified in writing of change in coverage.

Please fill in all sections that apply to your company, sign and return to us.

Business Name:			
Mailing address:			
Contact Person:			
Phone number:			
Entity type:	☐ Corporation	☐ Sole Proprietor	☐ Partnership
	☐ Limited Liability Company	☐ Other	

Select **only one** choice below:

☐ The person named below is choosing to be Included
☐ The person named below is choosing to be Excluded/Rejected
☐ The person named below is choosing to withdraw their previous inclusion of coverage
☐ The person named below is choosing to withdraw their previous exclusion/rejection of coverage

Type of Individual:	☐ Officer /Title		☐ Sole Proprietor
	☐ Member	☐ Partner	☐ Other
(Select only one of the above based on the business entity type in top section)			

(Please note: separate forms must be completed for each qualifying individual & each named insured on the policy)

Print Full Name:	Title:
Signature:	Date:
Effective Date of Coverage:	