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 Workersô 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 workersô 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** workersô 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 proprietorôs payroll limitations apply.