



## PARTNERSHIP EXCLUSION LETTER

<b>Date</b>			
<b>Group</b>	<b>Policy/Unit</b>	<b>Policy Year</b>	<b>Suffix</b>
<b>Employer Name</b>			
<b>Policy Period</b>	<b>From</b>	<b>To</b>	

**Please complete the following and return to State Fund. All general partners requesting exclusion must sign this letter if they are to be excluded.**

This business is operated as a partnership. The following individuals wish to be excluded from workers' compensation and employer's liability under this policy:

PRINT PARTNER'S NAME, TITLE	DATE OF EXCLUSION
PRINT PARTNER'S NAME, TITLE	DATE OF EXCLUSION
PRINT PARTNER'S NAME, TITLE	DATE OF EXCLUSION
PRINT PARTNER'S NAME, TITLE	DATE OF EXCLUSION

The individuals named above are either general partners or are shareholding officers of a corporation operating as a general partner, in which case the officers are the sole shareholders of the corporation.

We acknowledge that this exclusion does not relieve the partnership of any liability, which may exist for excluded individuals as employees under workers' compensation or employer's liability laws.

We further acknowledge that State Fund is not liable for any benefits or damages to any excluded employee should an injury occur.

We recognize State Fund reserves the right to enact this exclusion no sooner than the date and hour this letter is received by an authorized State Fund representative. **Failure to return this letter within 90 days will result in all general partners being included and additional premium will be charged.**

We will notify State Fund in writing of any change in the status of this partnership, its general partners and/or the desired coverage/exclusion status of the individuals named above.

By signing this exclusion letter, we acknowledge that the above partners have elected to be excluded from the State Fund workers' compensation policy.

GENERAL PARTNER'S SIGNATURE	DATE	GENERAL PARTNER'S SIGNATURE	DATE
GENERAL PARTNER'S SIGNATURE	DATE	GENERAL PARTNER'S SIGNATURE	DATE

<b>COPY TO:</b>	<b>IMAGING</b>	<b>REGIONAL OFFICE</b>	<b>EMPLOYER</b>
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# SUPPLEMENTAL APPLICATION FORM

NOTE: Please type or print clearly in ink. Shaded areas are for State Fund use only.

## Section 1 - Trade Name (i.e., DBA)

Current:

Prior (if applicable):

## Section 2 - Business Ownership

Legal Name:

Legal Entity (check one):

<input type="checkbox"/>	1	Individual (If married, check Husband & Wife)	<input type="checkbox"/>	N	Non-Profit Organization	<input type="checkbox"/>	C	Conservatorship
<input type="checkbox"/>	2	Husband & Wife (Both names required in Legal Name.)	<input type="checkbox"/>	3	Joint Venture	<input type="checkbox"/>	E	Estate
<input type="checkbox"/>	4	General Partnership	<input type="checkbox"/>	8	Public Agency	<input type="checkbox"/>	T	Trust
<input type="checkbox"/>	L	Limited Partnership	<input type="checkbox"/>	P	Incorporated Public Agency	<input type="checkbox"/>	6	Association
<input type="checkbox"/>	5	Corporation	<input type="checkbox"/>	9	Labor Union	<input type="checkbox"/>	J	Joint Employer
<input type="checkbox"/>	M	Non-Profit Corporation	<input type="checkbox"/>	U	Incorporated Labor Union	<input type="checkbox"/>	A	Common Ownership
						<input type="checkbox"/>	7	Other:

## Section 3 - Licenses

2101 Farm Labor Contractor License:

3405 Contractor's State License Board No./Type/Expiration Date:

3408 PUC/ICC License Number:

3409 Other License Numbers required to do business in CA (please specify):

## Section 4 - Additional Business Information

2075 Phones: Bus. ( ) - Home ( ) -

2075 FAX Number: ( ) -

2075 E-Mail Address:

2099 State Employer Identification Number:

## Section 5 - Social Security Number(s)

2096

Please provide the Social Security Number(s)\* for individual owner, husband, wife, corporate officers, or general partners. Attach a separate page if necessary.

(1) Name: _____	*Social Security Number: _____
(2) Name: _____	*Social Security Number: _____
(3) Name: _____	*Social Security Number: _____
(4) Name: _____	*Social Security Number: _____

### \*DISCLOSURE STATEMENT

Providing Social Security Numbers is voluntary. If the principals do not wish to provide Social Security Numbers, other acceptable identification shall include: 1) Federal Employer Identification Number (FEIN), 2) State Employer Identification Number (SEIN), 3) Contractor's License or 4) any applicable business license pertinent to the trade or business.

## Section 6 - General Information

Do any of the following pertain to the operations of this risk? Please explain all "yes" answers to questions 1-10 in the "Remarks" section on page 2.

	Yes	No		Yes	No
1. Use any equipment that bends, forms, shapes, or cuts materials (e.g., power press)?	<input type="checkbox"/>	<input type="checkbox"/>	8. Have any location/operations for which coverage is not requested?	<input type="checkbox"/>	<input type="checkbox"/>
2. Employ any relatives?	<input type="checkbox"/>	<input type="checkbox"/>	9. Have any operations outside of California?	<input type="checkbox"/>	<input type="checkbox"/>
3. Employ any minors (under age 18)?	<input type="checkbox"/>	<input type="checkbox"/>	10. Perform any asbestos removal?	<input type="checkbox"/>	<input type="checkbox"/>
4. Make any cash payments to employees or subcontractors?	<input type="checkbox"/>	<input type="checkbox"/>	11. Member of any trade or business association?	<input type="checkbox"/>	<input type="checkbox"/>
5. Provide meals or lodging in lieu of wages?	<input type="checkbox"/>	<input type="checkbox"/>	Please indicate: _____		
6. Pay any employees by the piece?	<input type="checkbox"/>	<input type="checkbox"/>	_____		
7. Have any work at a maritime or offshore facility?	<input type="checkbox"/>	<input type="checkbox"/>	_____		

## Section 7 - Has the business or any principal of the business declared bankruptcy in the last seven years? Yes No, skip to Section 8

Name of Principal:

3105 Chapter of bankruptcy filed (check as applicable):  7  11  13  Other:

Date filed: \_\_\_\_\_ Case Number: \_\_\_\_\_ Status:  pending  dismissed  discharged

Court where case was filed (Please provide us with a filed, stamped copy of the "Petition for Relief".):

## Section 8 - Was this operation all or part of an existing business that was purchased or acquired? Yes No, skip to Section 9

# SUPPLEMENTAL APPLICATION FORM

NOTE: Please type or print clearly in ink. Shaded areas are for State Fund use only.

What percentage of the business was acquired?: _____	Date ownership changed: _____
Prior business owner's name and address:	
Name: _____	
Address: _____	
Name of Business: _____	
Is the prior owner(s) related to the new owner(s)? <input type="checkbox"/> No <input type="checkbox"/> Yes, Relationship: _____	
Have the operations changed since the business was acquired (e.g., from a bakery to a restaurant)? <input type="checkbox"/> No <input type="checkbox"/> Yes, please explain: _____	
Were more than 50% of the current employees hired since the acquisition? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are those new employees earning more than 50% of the payroll? <input type="checkbox"/> Yes <input type="checkbox"/> No

### Section 9 - Management Practices

Please indicate if you offer: Employee Assistance Program <input type="checkbox"/>		Paid Vacations <input type="checkbox"/>		Paid Sick Leave <input type="checkbox"/>	
Do you have a minimum of 2 employees? <input type="checkbox"/> No <input type="checkbox"/> Yes					
If yes, do you offer the majority of your eligible employees Health Insurance? (eligible = works a minimum of 30 hrs./wk) <input type="checkbox"/> No <input type="checkbox"/> Yes					
If yes, do you pay at least 50% of the Health Insurance premium? <input type="checkbox"/> No <input type="checkbox"/> Yes, Name of Health Insurance Carrier: _____					
Please check off the hiring practices implemented by your company: Job Descriptions <input type="checkbox"/>		Pre-placement Medical Screening <input type="checkbox"/>			
Pre-placement Drug Testing <input type="checkbox"/>		Drug-free Workplace <input type="checkbox"/>		Pre-employment Reference Check <input type="checkbox"/>	
Union Employees <input type="checkbox"/>					
Do you have an injury and illness Prevention Program? <input type="checkbox"/> No <input type="checkbox"/> Yes					
Do you have a written early return-to-work program for employees injured on the job? <input type="checkbox"/> No <input type="checkbox"/> Yes					
Do you document: Employee Training <input type="checkbox"/>		Facility Inspections <input type="checkbox"/>			
Describe your housekeeping: Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/>		Describe the condition of your equipment: Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/>			
Have you received any OSHA citations within the past year? <input type="checkbox"/> No <input type="checkbox"/> Yes (Please explain in "Remarks.")					
Does the business provide temporary employees? <input type="checkbox"/> No <input type="checkbox"/> Yes (Please explain in "Remarks.")					

### Section 10 - Remarks (Attach a separate sheet if necessary.)

### Section 11 - Broker Information (For brokered accounts only, this section must be completely filled out by the producer.)

0030			
BROKER ACCESS NUMBER	FIRM NAME		
ADDRESS	CITY	STATE	ZIP
( ) -	( ) -		
PHONE NUMBER	FAX NUMBER		

### SIGNATURE

**To be completed by broker, owner, or an officer/partner (provide your title) of the business.**

Insurance Code Article 6, Sec. 11880 prohibits the willful misrepresentation of any fact in order to obtain lower insurance rates. State Fund reserves the right to verify the accuracy of information provided to it by insurance applicants.

**I confirm that the information on the ACORD and Supplemental Application is true and correct to the best of my knowledge.**

Name: _____	Title: _____
Please print	Please print
Signature: _____	Date: _____
<i>(FAXed applications must be followed up with original document/signature.)</i>	

## State Fund Offices

### **BAKERSFIELD**

9801 Camino Media  
Bakersfield, CA 93311  
(661) 664-4000

### **BAY AREA POLICY SERVICES**

5880 Owens Drive  
Pleasanton, CA 94588  
(925) 523-5100

### **EUREKA**

2440 Sixth Street  
Eureka, CA 95501  
(707) 443-9721

### **FRESNO**

10 River Park Place East  
Fresno, CA 93720  
(559) 433-2600

### **INLAND EMPIRE POLICY SERVICES**

375 West Hospitality Lane  
San Bernardino, CA 92408  
(909) 384-4500

### **LOS ANGELES**

900 Corporate Center Drive  
Monterey Park, CA 91754  
(323) 266-5000

### **ORANGE COUNTY POLICY SERVICES**

1750 East Fourth Street, 8<sup>th</sup> Floor  
Santa Ana, CA 92705  
(714) 565-5995

### **OXNARD**

2901 North Ventura Road  
Oxnard, CA 93036  
(805) 988-5200

### **REDDING**

2175 Shasta View Drive  
Redding, CA 96003  
(530) 223-7000

### **SACRAMENTO**

2275 Gateway Oaks Drive  
Sacramento, CA 95833  
(916) 924-5072

### **SAN DIEGO**

10105 Pacific Heights Blvd., #400  
San Diego, CA 92121  
(858) 552-7000

### **SAN JOSE**

6203 San Ignacio Avenue  
San Jose, CA 95119  
(408) 363-7600

### **SANTA ROSA**

1450 Neotomas Avenue  
Santa Rosa, CA 95405  
(707) 573-6300

### **STOCKTON**

3247 West March Lane  
Stockton, CA 95219  
(209) 476-2600