STATE OF ILLINOIS
WORKERS COMPENSATION
ELECTION FOR
EXCLUSION OF OFFICERS, PARTNERS OR SOLE PROPRIETOR

Name of Corporation or Business ____

Address of Corporation or Business ____

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Insurance Company ______________________________ Policy # ________________

I (We) officers, partners or sole proprietor of the above named corporation or business elect to be individually excluded from the Workers Compensation Insurance policy listed above and all renewals thereof.

Excluded Person(s)	Signature
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

Dated this _______ day of ________________________ 19 _____.

Effective Date of Exclusion ________________________

Date Received by Insurance Company ________________________