LOUISIANA

NOTICE OF ELECTION/REVOCATION OF COVERAGE

UNDER THE LOUISIANA WORKERS' COMPENSATION ACT

Federal Employer Identification Number (FEIN) | Company name

Address | City, State | ZIP code

Officer*/Sole Proprietor/Partner*/LLC Member*:

- ❑ I, the undersigned officer/sole proprietor/partner/LLC member of the above-named entity, do hereby **ELECT TO BE EXEMPT FROM COVERAGE** under the Louisiana Workers' Compensation Act L.S.A.R.S. 23:1035(A), effective on the date indicated below. It is further agreed that this election shall be in effect until the undersigned gives the carrier written notice to the contrary.
- ❑ I, the undersigned officer/sole proprietor/partner/LLC member of the above-named entity, do hereby **REVOKE THE EXEMPTION FROM COVERAGE** executed earlier and ***elect to be covered*** under the Louisiana Workers' Compensation Act L.S.A.R.S. 23:1035(A), effective on the date indicated below.

* An officer/partner/LLC member electing to be exempt from coverage must have at least 10% ownership in the company listed above. Each officer/sole proprietor/partner/LLC member must sign a separate form.

Signature | Date

Print name and title | Date of birth or Social Security number

Client number | Address

Insurance agent | Agency name

Agency address | City, State | ZIP code