



Accident Fund

INSURANCE COMPANY OF AMERICA
232 S Capitol Avenue
P O Box 40790
Lansing, MI 48901-7990

**Application for Exclusion from Coverage
Individual, Partner or Other**

Sec. 161 (2), Public Acts 317 of 1969 states in part: "A policy or contract of worker's compensation insurance, by endorsement, may exclude coverage as to any one (1) or more named partners, or the spouse, child or parent in the employer's family...."

It is understood and agreed that in accordance with the provision of Chapter 1, Sec. 161 (2), Public Acts 317 of 1969, I (we), whose signatures appear below, wish to be excluded from the benefits, as well as any succeeding policies.

I (we), the undersigned, agree to hold the Accident Fund harmless from and against all loss and expense because of injury or death sustained in my (our) employment.

Full Name (please print)	Signature	Title/Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

The following must be completed for this form to be valid

Individual owner's signature _____

Business Trade Name _____ City _____

Employer's Federal ID # _____ or Social Security # _____

Policy Number _____

Dated at _____ this _____ day of _____ 20____

This application is subject to approval and acceptance by the Home Office of the Accident Fund . The exclusion becomes effective when the endorsement is issued by the Home Office.

This signed form may be returned by fax. Please fax to your Underwriting Consultant.