

**ILLINOIS WORKERS COMPENSATION  
LIBERTY MUTUAL/COVENTRY PREFERRED PROVIDER PROGRAM  
EMPLOYER PARTICIPATION REJECTION**

Policy Number:	Policy Effective Date:
Company:	Agent:
Named Insured:	

By signing this waiver, I am rejecting participation within the Liberty Mutual/Coventry Preferred Provider Program. I knowingly and voluntarily reject participating in this program notwithstanding the benefits that this program may offer.

**If you do not understand the option outlined above, please contact your agent before you sign.**

By signing this document, you confirm your understanding that you reject participation in the Liberty Mutual/Coventry Preferred Provider Program. Your rejection will remain in effect for this policy term and for all future renewals or replacements of this policy. You can decide to participate at any time by notifying your insurance representative.

\_\_\_\_\_  
**Authorized Representative Name  
and Title** (Please Print)

\_\_\_\_\_  
**Authorized Representative  
Signature**

\_\_\_\_\_  
**Date**

Please submit this completed form to Helmsman Management Services at [IllinoisPPP@Libertymutual.com](mailto:IllinoisPPP@Libertymutual.com) or to your account representative.