Form: S-2A (1-2016)

State of California
Department of Industrial Relations
Office of Self-Insurance Plans
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State of California
Department of Industrial Relations
OFFICE OF SELF-INSURANCE PLANS

GROUP AFFILIATE MEMBER INTERIM APPLICATION

DATE: _____ GROUP CERT. # _____

GROUP NAME: _____

AFFILIATE MEMBER (Legal Name): _____

Principal California Address: _____

City: _____ State: _____ Zip _____ Phone _____

TYPE OF ENTITY OWNERSHIP: ☐ Corporation ☐ Partnership ☐ Sole Proprietorship

State of Incorporation (if Corporation): _____

Federal Tax Identification Number of Group Member: _____

Requested Effective Date of Interim Certificate: _____

Nature of Business: _____

3-digit NAICS Code: _____ OR 2-digit SIC Code: _____ Current experience modification: _____

Member's annual California payroll during the last, or latest 12 month period:

$ _____ Period Reported: _____ to _____.

The Interim Certificate will be valid for 180 Days. The Self-Insured Group agrees to be financially responsible to pay all workers' compensation claim liabilities for the above Affiliate Group Member.

X_____
SIGNED: Group Authorized Representative

_____
Printed Name & Title

_____
Address

_____
City, State, Zip+4

_____
Phone