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