



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