



State of California  
Department of Industrial Relations  
OFFICE OF SELF-INSURANCE PLANS

**PRIVATE / PUBLIC INTERIM APPLICATION**

Issuance of a Private Affiliate or Subsidiary interim certificate as identified below:

DATE: \_\_\_\_\_ CERT. # \_\_\_\_\_

MASTER CERTIFICATE HOLDER NAME: \_\_\_\_\_

Applicant (Legal Name): \_\_\_\_\_

Federal Tax Identification Number of Applicant: \_\_\_\_\_

Principal California Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Requested Effective Date of Interim Certificate: \_\_\_\_\_

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

**X** \_\_\_\_\_  
SIGNED: Employer Authorized Representative

\_\_\_\_\_  
Printed Name & Title

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip+4

\_\_\_\_\_  
Phone