STATE COMPENSATION INSURANCE FUND

REQUEST FOR CERTIFICATE OF INSURANCE

Attention: **Certificates Department**
1750 E. 4th Street
Santa Ana, CA 92705

Phone (714) 565-5998 or 565-5999
FAX (866) 266 2071

RUSH FAX: YES___ NO___ FAX NUMBER (___)_____
(CERTS TO BE FAXED ONLY IF JOB OR PAYMENT BEING HELD UP)

Policy or Group Number: _____ Unit Number: _____ Policy Year: _____

Legal Name of Company: _____

_____

Mailing Address: _____

_____

Phone Number: (___)_____ FAX Number: (___)_____

PLEASE PROVIDE A CERTIFICATE OF INSURANCE TO:

Company Name: _____

Attention: _____

Address: _____

_____

License/Permit/Registration No. (if required): _____

Job/Contract No. if required ("ALL OPERATIONS" is standard): _____

ENDORSEMENT(S) -- SPECIAL CERTIFICATE REQUEST

( ) Additional Insured (MUST CORRESPOND TO THE NAME OF THE CERTIFICATE OF INSURANCE REQUESTOR ABOVE
( ) 30 days advance notice of cancellation to certificate holder request (10 days is the usual notice)
( ) Indicate Employer's Limit of Liability
( ) Waiver of Subrogation (AUTHORIZED SIGNATURE REQUIRED)

I understand that any agreement tending to waive the right of State Compensation Insurance Fund to subrogation must be set forth as an endorsement to the policy and must include a provision for an additional premium charge of not less than 3% of the workers' compensation premium involved. We will keep the payroll involved on this job segregated. If we fail to keep the payroll segregated, I understand the additional premium charge will be applied to our entire payroll.

Authorized By: _____ Signature: _____

Title: _____ Date: _____