



MEMBERSHIP APPLICATION FORM State Fund Group Program

Company Name: _____

Contact Name: _____ Title: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Email Address: _____

Number of Employees: _____ Annual Gross Revenue: _____

Dues Schedule: Membership in our Group Worker's Compensation Insurance Program provided by State Compensation Insurance Fund (SCIF) is based on your estimated premium amount. Please see the following chart to determine the appropriate annual dues for your policy.

\$0.00	-	\$1,000	=	\$50.00
\$1,001	-	\$5,000	=	\$75.00
\$5,001	-	\$12,000	=	\$200.00
\$12,001	-	UP	=	\$300.00

Please mail back your check and application form to CCC headquarters.