



## 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 - \$5,000 = \$100.00

\$5,001 - \$12,000 = \$200.00

\$12,001 - UP = \$300.00

Allow company information to be published on our Membership Roster      YES      NO

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