MEMBERSHIP APPLICATION FORM

Regular Member (For Hire Carrier) ☐
Affiliate Member (Sells to or provides products to the Regular Members Companies) ☐

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	=	$75.00
$5,001	-	$12,000	=	$200.00
$12,001	-	Up	=	$300.00

Non SCIF Regular group members: $300.00 ☐
Affiliate members: $300.00 ☐

Method of Payment: Check enclosed ☐ Visa ☐ Mastercard ☐ Discover ☐

Card No. ___________________________ Exp. Date:_____/_____

Signature:____________________________________ Date:_______________

Please mail back your check or fax the application form with your credit card payment information to CCC headquarters.

2398 Fair Oaks Boulevard, Suite 1A · Sacramento , CA 95825 · 916.480.9942 · 888.338.0208 · Fax 916.489.3280
www.consolidatedcarriersofcalifornia.com