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

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

2398 Fair Oaks Boulevard, Suite 1A • Sacramento, CA 95825 • 916.480.9943 • Fax 916.489.3280
www.ccaaassn.biz