

State Compensation Insurance Fund
Sacramento Group Program
2300 River Plaza Drive, Suite 150
Sacramento, CA 95833-2293

Policy Conversion Request

CALIFORNIA HEALTHCARE PROVIDER SERVICES (#488)

Name of Business: _____

To Whom It May Concern:

State Compensation Insurance Fund is currently providing coverage for our workers' compensation insurance.

Individual Policy Number: _____

Expiration Date: _____

Please consider this document as authorization to transfer my individual policy into the California Healthcare Provider Services-CCCMHA group policy with State Fund. I am currently a member or will become a member of California Healthcare Provider Services.

Principal Owner's Signature _____

Date _____

Broker signature is required to request conversion review.

(Broker Signature)

Copy to Association