



NAME OF BUSINESS: _____

ADDRESS: _____

CITY: _____ STATE _____ ZIP _____

TO WHOM IT MAY CONCERN:

THE STATE COMPENSATION INSURANCE FUND IS CURRENTLY PROVIDING
COVERAGE FOR OUR WORKER'S COMPENSATION INSURANCE.

POLICY NUMBER: _____

EXPIRATION DATE: _____

I AM CURRENTLY A MEMBER OF, OR WILL JOIN

**UNITED HIGHWAY CARRIERS ASSOCIATION
GROUP 404**

PLEASE CONSIDER THIS DOCUMENT AS AUTHORIZATION TO TRANSFER MY
POLICY INTO THIS ASSOCIATION'S GROUP POLICY WITH THE STATE FUND.

SIGNATURE: _____

TITLE: _____

DATE _____

Please mail or fax completed form to United Highway Carriers Association,
Group Program # 404, PO Box 675, Applegate CA. 95703
Fax: 530-878-8609 / Phone: 877-235-2968