

CALIFORNIA CONTRACTORS NETWORK, INC.

REQUEST FOR WORKERS COMP CERTIFICATE OF INSURANCE

Date: _____

Member Name: _____

Point of Contact: _____

Phone # (required): _____ Fax # (required): _____

Check applicable box:

Certificate

Certificate with Waiver of Subrogation

Final Certificate: Start Date: _____ Completion Date: _____

CERTIFICATE HOLDER INFORMATION:

Name: _____

Address: _____

City, State, Zip: _____

Job/Project Name (if applicable): _____

ALL CERTIFICATES WILL BE MAILED TO THE INSURED & THE CERTIFICATE HOLDER

Special Requests: _____

Email Request to wccerts@calsig.com or Fax to 800-592-2541

IF YOU HAVE ANY QUESTIONS CALL SELF INSURED SOLUTIONS, LLC

Attn: Damaris Hair

AT 800-592-0047