STATE OF CALIFORNIA – DEPARTMENT OF INDUSTRIAL RELATIONS

DIVISION OF LABOR STANDARDS ENFORCEMENT

REPORT ON WORKERS' COMPENSATION INSURANCE

NOTE: Please disregard this form if you are a Federal or State agency or any of its political subdivisions; or a welfare recipient receiving In-Home Supportive Services (IHSS).

OFFICIAL NOTICE

State Labor Code Section 3711 requires you to furnish the information requested below. *FAILURE TO COMPLETE AND RETURN THIS FORM WITHIN 10 DAYS MAY SUBJECT YOU TO A $500 PENALTY.*

This is to inform you, as an employer, that if you have one or more, full-time or part-time employees, you must be insured for Workers' Compensation.

Please read the requirements of the California law on the reverse side of this form. Then complete the information requested herein, and return this form within 10 days to the office of the Labor Commissioner, using the enclosed envelope.

NAME OF EMPLOYER	NO. OF EMPLOYEES
TYPE OF BUSINESS (Retail, restaurant, insurance, etc.)	TELEPHONE NO. (Area Code & No.)
ADDRESS OF BUSINESS (Give California location if Main Office is out of state)	
NAME OF WORKERS' COMPENSATION INSURANCE CARRIER	POLICY NO.
NAME & ADDRESS OF INSURANCE AGENT OR BROKER (If any)	
NAME OF INSURED EMPLOYER (As shown on Policy)	PERIOD COVERED From ______ To ______

Are there persons working for you who are specifically exempt from coverage? *(Note: Spouses and relatives are NOT exempt.)* ☐ NO ☐ YES — If Yes, Please Fill In Below:

CATEGORIES OF EXEMPTED EMPLOYEES	REASONS FOR EXEMPTION

REASONS FOR NONINSURANCE (Such as No Employees, Out of Business, Covered by Federal Law, etc.)

I HEREBY CERTIFY THE ABOVE TO BE CORRECT

NAME & SIGNATURE OF OWNER, OR PARTNER, OR CORPORATE OR ASSOCIATION OFFICER

TITLE	DATE