

# Information Request Form

Please complete the entire Information Request Form and provide all requested attachments. The information provided will be used to complete the required forms for the Application for an Affiliate Member Certificate of Consent to Self-Insure as a Member of Post Time Self Insurance Group (PTSIG). Once the application has been completed, it will be returned for review and execution.

Please submit the completed Information Request form, along with all requested attachments to the attention of:

Ms. Allie Rodriguez  
Post Time Self Insurance Group  
4961 Katella Avenue  
Los Alamitos, CA 90720  
Phone: 714-820-2743  
Fax: 714-820-2813  
E-mail: [yeliser@sigsolutionsca.com](mailto:yeliser@sigsolutionsca.com) or [allier@sigsolutionsca.com](mailto:allier@sigsolutionsca.com)

**Please check ✓ to ensure you have completed and/or attached the following items.**

1. Applicant Contact (Name and Title): \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Email: \_\_\_\_\_

2. Legal Name of (Entity) Applicant: \_\_\_\_\_  
DBA Name if Applicable: \_\_\_\_\_

3. Principal Mailing Address: \_\_\_\_\_  
Principal Physical Address: \_\_\_\_\_

3a. Where are you going to be stabled?: \_\_\_\_\_  
Number of Allotted Stalls: \_\_\_\_\_

4. The Applicant is:  
 A Corporation       A Partnership       A Sole Proprietorship       An LLC or LLP

**If a Corporation, LLC, or LLP:**

State of Incorporation: \_\_\_\_\_  Date of Incorporation: \_\_\_\_\_

Please list two (2) officers, including their title, who are authorized to sign official documents on behalf of the Applicant. Please be sure the titles are listed as you would like them read in the Model Private Group Member Corporate Resolution. The Model Private Group Member Corporate Resolution is a requirement of the DIR OSIP and is referenced below.

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Name: \_\_\_\_\_ Title: \_\_\_\_\_

5. Federal Tax Identification Number or SS #: \_\_\_\_\_

6. Name of current workers' compensation carrier: \_\_\_\_\_

7. Renewal date of current workers' compensation policy: \_\_\_\_\_

8. Desired effective date of membership if different than renewal date above: \_\_\_\_\_

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9. Number of California employees to be covered under the proposed membership: \_\_\_\_\_

10. Provide Profit or (Loss) after taxes for the last three (3) complete years, as follows:

<u>Year</u>	_____
2022	\$ _____
2021	\$ _____
2020	\$ _____
	_____

11. Provide premium paid for workers' compensation insurance and experience modification factor (ex-mod) for the last four (4) complete years, including current year, as follows:

<u>Year</u>	<u>Premium</u>
2022	\$ _____
2021	\$ _____
2020	\$ _____
2019	\$ _____
	_____

12. List the names of the horses you are bringing on to the track:


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Having read and completed the foregoing Information Request Form, the Applicant agrees that this Form and all supporting attachments become a part of the prospective new member's membership acknowledgments. Furthermore, the Applicant agrees they will supply all supplemental information as required by the PTSIG Administrator or the State of California, in a timely manner. The Applicant acknowledges that completion of this Information Request does not constitute approval of membership by the PTSIG Board of Trustees or the State of California.

Read and Acknowledged by:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Title: \_\_\_\_\_

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