STATE COMPENSATION INSURANCE FUND

P.O. BOX 8192, PLEASANTON, CA 94588

# CERTIFICATE OF WORKERS' COMPENSATION INSURANCE

**ISSUE DATE: 04-01-2026**

GROUP:
POLICY NUMBER: **9050096-2026**
CERTIFICATE ID: **2**
CERTIFICATE EXPIRES: **04-01-2027**
**04-01-2026/04-01-2027**

**CALIFORNIA DEPARTMENT OF MOTOR VEHICLES SP**
**MOTOR CARRIER PERMIT BRANCH**
**PO BOX 932370**
**SACRAMENTO CA 94232-3700**

**CA#: 0384729**
**INCEPTION DATE:04-01-2026**
**DO:SP**

This is to certify that we have issued a valid Workers' Compensation insurance policy in a form approved by the California Insurance Commissioner to the employer named below for the policy period indicated.

This policy is not subject to cancellation by the Fund except upon **30** days advance written notice to the employer.

We will also give you **30** days advance notice should this policy be cancelled prior to its normal expiration.

This certificate of insurance is not an insurance policy and does not amend, extend or alter the coverage afforded by the policy listed herein. Notwithstanding any requirement, term or condition of any contract or other document with respect to which this certificate of insurance may be issued or to which it may pertain, the insurance afforded by the policy described herein is subject to all the terms, exclusions, and conditions, of such policy.

Authorized Representative

President and CEO

**EMPLOYER'S LIABILITY LIMIT INCLUDING DEFENSE COSTS: $1,000,000 PER OCCURRENCE.**