

2503 EASTBLUFF DR. SUITE 204,
NEWPORT BEACH CA 92660.
WWW.CALSRA.COM
NIHA@CALSA.COM
PHONE: 949-756-1654
FAX: 949-251-9620



SENTINEL RESTAURANT ASSOCIATION ENROLLMENT APPLICATION

Full name of the Applicant: _____

Business Name: _____

Mailing Address: _____

Agent Name: _____ Agent Phone #: _____

Agent Email: _____

Policy Number: _____ Effective Date: _____

****Safety group annual membership dues are \$50.00.****

****Make check payable to Sentinel Restaurant Association.****

****This application can also be done online and payment can be made by Credit/Debit card or EFT at www.calsra.com****

Declaration of Application for Safety Group Membership

The Applicant is a member of the Sentinel Restaurant Association. The Applicant agrees to promptly pay all Group Worker's Compensation premiums and deposits when billed and due. The Applicant understands and agrees that upon failure to pay any outstanding financial obligations due on his account to the Insurer, or to maintain Association membership, the Applicant will immediately cease to be a Group Member, any information held by the Insurer relating to claims, experience rating, loss prevention services or other information which may be the subject of Group research and inquiry.

The Applicant understands that:

1. Individual Worker's Compensation policies are considered for issuance to Association members in accordance with applicable rules and regulations, as determined by the insurance carrier.
2. Active participation in the safety activities of the Group is requirement for continued membership in the Group. Dates and amounts of distribution may vary according to the policies of the Insurer or Trustees

Acknowledgement of the Declaration: _____ Applicant

_____ Date