

Commonwealth of Massachusetts
Department of Industrial Accidents - Office of Insurance
Lafayette City Center, 2 Avenue de Lafayette, Boston, MA 02111



Subsidiary Addendum Form

CHECK ONE

Page ____ of ____.
(Use additional pages as needed)

___ New Application
___ Renewal Application – Self-Insurer License No.: _____

Subsidiary Addendum to the Self-Insurance Application of: _____
(Parent Corporation)

Effective Date: _____

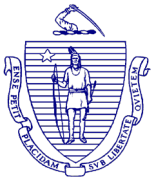
Subsidiary	Business Type	#Employees	Payroll	Unmodified Premium
Name: _____				
Address: _____				

Subsidiary	Business Type	#Employees	Payroll	Unmodified Premium
Name: _____				
Address: _____				

Subsidiary	Business Type	#Employees	Payroll	Unmodified Premium
Name: _____				
Address: _____				

Subsidiary	Business Type	#Employees	Payroll	Unmodified Premium
Name: _____				
Address: _____				

Subsidiary	Business Type	#Employees	Payroll	Unmodified Premium
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Signed under the pains and penalties of perjury by:

Print Name: _____ **Title:** _____ **Date:** _____

Signature: _____