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
Name:				
Address:				

Signed under the pains and penalties of perjury by:

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

Signature: _____