



# AGENT/BROKER OF RECORD CHANGE

DATE (MM/DD/YYYY)  
6/19/2013

AGENCY	PHONE (A/C, No, Ext): (818)985-5510	INSURANCE COMPANY NAME State Compensation Insurance Fund 900 Corporate Center Drive Monterey Park CA 91754
	FAX (A/C, No): (818)985-7747	
Lemark Insurance Agency, Inc. 11494 Burbank Blvd North Hollywood CA 91601		
E-MAIL ADDRESS:		
CODE:	SUBCODE:	
AGENCY CUSTOMER ID: 00013188		

POLICY NUMBER(S)	EFFECTIVE DATE	EXPIRATION DATE	LINE OF BUSINESS
TO FOLLOW	6/19/2013	6/19/2014	Workers Compensation

Please be advised that we wish to name Lemark Insurance, Inc.  
 \_\_\_\_\_  
 \_\_\_\_\_ as our exclusive representative effective \_\_\_\_\_  
 507897 \_\_\_\_\_  
 CODE # PRODUCER DATE

for the lines of business shown above, currently in force or submitted by application.

This authorization replaces any other authorization that may have been previously completed for any other insurance representative for the stated lines of business.

\_\_\_\_\_  
 INSURED'S SIGNATURE DATE

\_\_\_\_\_  
 TITLE (IF APPLICABLE)

\_\_\_\_\_  
 COMPANY NAME (IF APPLICABLE)