

California Optometric Association

sponsored Employment Practices Liability Insurance Program

Premium Indication Request

3-860W

For a premium indication, please complete the following information and fax it to: **213-346-5946**

Personal Information

Member Name: _____ O.D.

Practice Name: _____

Address: _____

City: _____ State: CA Zip: _____

Phone: (_____) _____ Fax: (_____) _____

E-Mail Address: _____ Contact: _____

Best Day and Time to contact: _____

Coverage Requested

I authorize Marsh to request an Employment Practices Liability Insurance premium indication from a surplus lines carrier (rated "A" by A.M. Best).

- Limits of Coverage desired: \$250,000 per claim / \$250,000 aggregate
 \$500,000 per claim / \$500,000 aggregate
 \$1,000,000 per claim / \$1,000,000 aggregate
- Number of Employees: _____ Full time
_____ Part time
- Do you currently have a stand alone Employment Practices Liability Policy? Yes No
- In the last five years, have you had any Employment Practices claims or any known situations that could give rise to a claim? Yes No

Additional Information Request *(Please check below to receive information on these additional sponsored plans.)*

- | | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Medical:
<input type="checkbox"/> Individual
<input type="checkbox"/> Small Group (2 – 50)
<input type="checkbox"/> Large Group (51+)
<input type="checkbox"/> High Deductible Health Plan (for HSAs)
<input type="checkbox"/> PPO
<input type="checkbox"/> HMO | <input type="checkbox"/> Workers' Compensation
<input type="checkbox"/> Business Owners Package
<input type="checkbox"/> Professional Liability
<input type="checkbox"/> Long Term Care | <input type="checkbox"/> Long Term Disability
<input type="checkbox"/> Business Overhead Expense
<input type="checkbox"/> Term Life
<input type="checkbox"/> Group Universal Life | <input type="checkbox"/> Group Dental
<input type="checkbox"/> Auto & Homeowners
<input type="checkbox"/> Accidental Death & Dismemberment |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|

Signature:

I authorize Marsh to obtain an Employment Practices Liability insurance premium indication on my behalf:

Signature: _____ Date: _____

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777 South Figueroa Street, Los Angeles, CA 90017 • (800) 775-2020 • COA.Insurance@marsh.com • www.MarshAffinity.com • 6/08

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