

California Optometric Association

sponsored Medical Insurance Program

#3-852W

For information or a quote, please complete the following information and fax it to Marsh at: **213-346-5946**

Personal Information

Member Name: _____

Practice Name: _____

Address: _____

City: _____ State: CA Zip: _____

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

E-Mail Address: _____ Member's Date of Birth: ____/____/____

Information/Coverage Requested (Choose coverage type and carriers you would like a quote from:)

I already have a Small Group Medical plan through Marsh:

I would like to start using Mercer Select HRKnowHow

Plan Type:

PPO HMO High Deductible Health Plan (for HSAs)

Small Group: (2-50 employees)

Aetna Blue Cross Blue Shield
 HealthNet Kaiser PacifiCare

Health Savings Account Only:

I already have a qualifying High Deductible Health Plan. Please send me information on Health Savings Accounts.

I'd rather have someone call me to discuss my options.

I'm not interested in the Medical plans, but I would like to ask about other options. Please call me.

Contact Name: _____

Phone Number: (_____) _____

Best time to call: _____

Plan: _____

Census Information (Required for a quote)

	Birthdate	Zip Code	Coverage Level	Gender (M/F)
1	□□/□□/19□□	□□□□□□	□□	□
2	□□/□□/19□□	□□□□□□	□□	□
3	□□/□□/19□□	□□□□□□	□□	□
4	□□/□□/19□□	□□□□□□	□□	□

Fill out the birthdate, home zip code, coverage level and gender for each member/employee to be insured. For the coverage level, use the following:

EE = Employee Only
 ES = Employee and Spouse
 EC = Employee and Child(ren)
 FA = Family

If you have additional employees, please continue on a separate sheet. Or send a census or copy of a recent invoice.

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

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Workers' Compensation | <input type="checkbox"/> Long Term Care | <input type="checkbox"/> Term Life | <input type="checkbox"/> Accidental Death & Dismemberment |
| <input type="checkbox"/> Employment Practices Liability | <input type="checkbox"/> Business Owners Package | <input type="checkbox"/> Group Universal Life | <input type="checkbox"/> Auto & Homeowners |
| <input type="checkbox"/> Long Term Disability | <input type="checkbox"/> Professional Liability | <input type="checkbox"/> Dental | |
| <input type="checkbox"/> Business Overhead Expense | | | |