

Workers' Compensation Premium Indication Form

Sponsored by the California Optometric Association. For more information complete the form below and fax to Marsh at 213-346-5946. Or scan and e-mail to COA.Insurance@marsh.com

Member Information

Member Name _____
 Practice Name _____
 Address _____
 City _____ State **CA** Zip _____
 Phone (_____) _____ Fax (_____) _____
 E-mail Address _____ Contact _____

Workers' Compensation *For information and a premium indication, please include the following:*

Present Workers' Compensation Carrier _____
 Current Rate (Per \$100) _____ Policy Renewal Date _____
 Number of Employees: Full-Time _____ Part-Time _____ Annual Employee Payroll \$ _____
 Are any officers/partners included in annual payroll above?..... Yes..... No
 If "Yes," to be excluded?..... Yes..... No..... If "Yes," exclude from above payroll: \$ _____
 If incorporated, do you wish coverage for yourself? Yes No **NOTE: All officers who do not own stock must be covered.**
 Years in Business _____ Individual Partnership Corporation
 Joint Employers Limited Corporation "S" Corporation
 Is group medical insurance provided? Yes No If Blue Cross, Group # _____

Additional Programs

Please send me information on these additional sponsored programs:

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

Signature

I authorize Marsh to obtain a Workers' Compensation insurance premium indication(s) on my behalf.

Signature: **X** _____ Date: **X** _____

Sponsored by:



Underwritten by:



Administered by:



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