

Workers' Compensation Premium Indication Form

3-859W

Sponsored by the California Optometric Association

Fax this form to: **(213) 346-5946** or call: **(800) 775-2020**

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: \$ _____

Is your spouse included 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.**

Group health insurance provided?.... No..... Yes..... If yes, name of insurer: _____

Additional Programs:

Please send me information on these additional sponsored programs:

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

Signature:

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

Signature: _____ Date: _____

Sponsored by:



Administered by:

**Republic
Indemnity**

MEMBER OF **GREAT AMERICAN**
INSURANCE GROUP

Administered by:

MARSH

MMC MARSH MERCER KROLL
GUY CARPENTER OLIVER WYMAN