

# Business Owners Package Premium Indication Form

4-159w

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

## Member Information:

Pharmacist Name \_\_\_\_\_  
Pharmacy Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone (\_\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_\_) \_\_\_\_\_  
E-mail Address \_\_\_\_\_ Contact \_\_\_\_\_ Best time to call \_\_\_\_\_  
How long have you owned your pharmacy? \_\_\_\_\_

## Business Owners Package *For a premium indication, please include the following information:*

**Business Type**  Individual  Corporation  Partnership  Other (describe) \_\_\_\_\_  
**Pharmacy Type**  Community Pharmacy  Closed Door Pharmacy  Other \_\_\_\_\_  
**Limits**  \$2 million/\$4 million  Include expanded Pharmacy Services wording  
Annual Prescription Drug Receipts \$ \_\_\_\_\_ Number of Scripts filled daily \_\_\_\_\_  
Number of full-time pharmacists \_\_\_\_\_ Number of full-time technicians \_\_\_\_\_  
Current policy expiration date \_\_\_\_\_ Current Carrier \_\_\_\_\_  
Any claims in the last 3 years?  No  Yes Business Personal Property \$ \_\_\_\_\_  
Check one  Tenant  Building Owner – Building Limit, if Owner: \$ \_\_\_\_\_  
Sprinklered  No  Yes Alarm  Central  Local Age of Building \_\_\_\_\_  
Building Construction  Frame  Joisted Masonry  Masonry Noncombustible  Noncombustible  Fire Resistive

## Workers' Compensation *Complete only if not with Fireman's Fund® Insurance Company:*

Present Workers' Compensation Carrier \_\_\_\_\_  
Current Rate (Per \$100) \_\_\_\_\_ Policy Renewal Date \_\_\_\_\_  
Number of Employees Full-time \_\_\_\_\_ Part-time \_\_\_\_\_ Annual Employee Payroll \$ \_\_\_\_\_  
If incorporated, do you wish coverage for yourself or any other officers who own stock?  No  Yes  
Do you provide Group Health Insurance?  No  Yes. . . If Blue Cross, please provide Group # \_\_\_\_\_

## Signature:

I authorize Marsh to obtain a Business Owners Package and/or Workers' Compensation insurance premium indication(s) on my behalf:

Signature X \_\_\_\_\_ Date X \_\_\_\_\_



*The insurance policy, not this letter, forms the contract between the insured and the insurance company. The policy may contain limits, exclusions, and limitations that are not detailed in this letter. Coverages may differ by state.*