

# California Pharmacists Association

## sponsored Employment Practices Liability Insurance Program

### Premium Indication Request

4-158w

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

#### Personal Information

Member Name: \_\_\_\_\_

Pharmacy 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:<br><input type="checkbox"/> Individual<br><input type="checkbox"/> Small Group (2 – 50)<br><input type="checkbox"/> Large Group (51+)<br><input type="checkbox"/> High Deductible Health Plan (for HSAs)<br><input type="checkbox"/> PPO<br><input type="checkbox"/> HMO | <input type="checkbox"/> Workers' Compensation<br><input type="checkbox"/> Business Owners Package<br><input type="checkbox"/> Professional Liability<br><input type="checkbox"/> Long Term Care | <input type="checkbox"/> Long Term Disability<br><input type="checkbox"/> Level Term Life<br><input type="checkbox"/> Auto & Homeowners | <input type="checkbox"/> Catastrophe Major Medical<br><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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