

California Pharmacists Association

sponsored Medical Insurance Program

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

Personal Information

Member Name: _____

Pharmacy Name: _____

Address: _____

City: _____ State: **CA** Zip: _____

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

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

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

<p>Plan Type:</p> <p><input type="checkbox"/> PPO <input type="checkbox"/> HMO <input type="checkbox"/> High Deductible Health Plan (for HSAs)</p> <p>Small Group: (2-50 employees)</p> <p><input type="checkbox"/> Aetna <input type="checkbox"/> Blue Cross <input type="checkbox"/> Blue Shield <input type="checkbox"/> HealthNet <input type="checkbox"/> Kaiser <input type="checkbox"/> PacifiCare</p> <p>Individual:</p> <p><input type="checkbox"/> Aetna <input type="checkbox"/> Blue Cross <input type="checkbox"/> Blue Shield</p> <p>Health Savings Account Only:</p> <p><input type="checkbox"/> I already have a qualifying High Deductible Health Plan. Please send me information on Health Savings Accounts.</p>	<p><input type="checkbox"/> I'd rather have someone call me to discuss my options.</p> <p><input type="checkbox"/> I'm not interested in the Medical plans, but I would like to ask about other options. Please call me.</p> <p>Contact Name: _____</p> <p>Phone Number: (_____) _____</p> <p>Best time to call: _____</p> <p>Plan: _____</p>
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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"/> Business Owners Package	<input type="checkbox"/> Employment Practices Liability	<input type="checkbox"/> Term Life	<input type="checkbox"/> Catastrophe Major Medical
<input type="checkbox"/> Professional Liability	<input type="checkbox"/> Long Term Disability	<input type="checkbox"/> Group Universal Life	<input type="checkbox"/> Accidental Death & Dismemberment
<input type="checkbox"/> Workers' Compensation	<input type="checkbox"/> Long Term Care	<input type="checkbox"/> Auto & Homeowners	