

California Pharmacists Association Sponsored California Workers' Compensation Program Application

Check one: Please issue a quote Please consider this application as a request for coverage

Proposed Effective Date: From: _____ To: December 1, 200 _____. At 12:01 a.m. Pacific Standard Time as to each of said dates.

EMPLOYER INFORMATION		Broker Code & Name: _____
Member/Pharmacist In Charge Name	Years in Practice	
Employer Name (including DBA)	Years in Business / At This Location?	
Address	Billing <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly	
City State CA Zip	Federal Employer ID#	
Phone ()	Fax ()	E-mail Address
Do you have Additional Locations? <input type="checkbox"/> Yes <input type="checkbox"/> No – If yes, please list each location on a separate page with payroll and number of full time and part time employees at each.		<input type="checkbox"/> Individual <input type="checkbox"/> Joint Employers
<input type="checkbox"/> Community Pharmacy <input type="checkbox"/> Closed Door Pharmacy <input type="checkbox"/> Long Term Care		<input type="checkbox"/> Partnership <input type="checkbox"/> Limited Corporation
<input type="checkbox"/> Other (please specify):		<input type="checkbox"/> Corporation <input type="checkbox"/> "S" Corporation
Is the sum of the following operations less than 25% of your total office payroll? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		
• Health Care Screenings • Nursing Activities • Home Health Care • Deliveries (Except Closed Door Pharmacies) • Heavy DME Rental & Delivery		

EMPLOYEE INFORMATION						
Code #	Classification	# of Employees		Estimated Annual Payroll	Average Hourly Wage	Estimated Annual Premium
		Full-Time	Part-Time			
8017	Pharmacies Stores – Retail – NOC					
	Partners, Officers, Non-residing relatives to be covered					
8810	Clerical Office Employees					
	Delivery					
8742	Sales					
	Other					

INDIVIDUAL				
Employed Relatives' Names	Age	Relationship	Residing With Insured?	Duties & Estimated Salary
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	

CORPORATION OR PARTNERSHIP				
Name of Officer/Director or General Partner	Title	% Stock Owned (Corp. Only)	To be Covered?	Signature of Officer/Director or General Partner if NOT Covered
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	

Ownership Must Total 100% (Corporations Only): 100%

If you have additional locations, please attach a separate page with each address, number of employees and payroll at each location.

Employer Name/DBA: _____

19. Please list your previous carrier information for the past 3 years below. **Attach claims history for each of the companies listed.** (This information is required to approve your coverage.)

PREVIOUS INSURANCE CARRIER – Last 3 years experience required.						
Previous Carrier	Policy Number	Period	Premium	Losses (Please describe in detail below)	Valued Date	Loss Ratio

a. If a new venture, number of years prior experience: _____ b. Number of years licensed: _____

c. Any prior ownership and/or management experience:.... Yes.... No....If yes, please explain:

20. Has any prior coverage been declined/cancelled/non-renewed in the last 4 years? No Yes (Provide details on separate sheet)

Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties.

I authorize Marsh to collect, use and disclose loss run information from my former workers' compensation insurance policies solely for the purpose of obtaining replacement coverage. I authorize Marsh to obtain proposals on my behalf from the program insurers. They are authorized to release to prospective insurers the name of my current insurer, pricing and policy terms. They may also release to prospective insurers the results of other competitive bids in order to allow an insurer to submit an improved quote. I will advise Marsh in writing if I do not want any of the above information released.

Officer's Signature: _____ **Date:** _____

Completed by: _____

To Be Completed by Agent:

Producer's Signature: _____ **Agent Name:** _____

Producing Retail Agency (if not Marsh): _____ **Tax ID #:** _____

Agent Address: _____ **Phone: ()** _____

City, State, Zip: _____ **Code:** _____

Please mail the completed application to:

Marsh/Seabury & Smith
777 South Figueroa Street
Los Angeles, CA 90017

Or fax your application to:
1-213-346-5946.

Questions?

Please call a Client Service Representative for help: **888-926-CPhA**

Administered by:

MARSH

Seabury & Smith Insurance Program
Management • CA License #0633005
777 South Figueroa St., Los Angeles, CA 90017
(888) 926-CPhA • www.marshaffinity.com
CPhA.Insurance@marsh.com • 10/07
4-857W

Underwritten by:



The premium rates quoted include compensation of 14% from Fireman's Fund Insurance Company received by Marsh for providing services that may include underwriting applications, issuing policies, ongoing servicing, billing, communications and marketing.

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