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, 20_______. 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 ☐ Annual ☐ Semi-Annual ☐ Quarterly
City State CA Zip	Federal Employer ID#
Phone ( ) Fax ( )	E-mail Address
Do you have Additional Locations? ☐ Yes ☐ No – If yes, please list each location on a separate page with payroll and number of full time and part time employees at each. ☐ Community Pharmacy ☐ Closed Door Pharmacy ☐ Long Term Care ☐ Other *(please specify)*:	☐ Individual ☐ Joint Employers ☐ Partnership ☐ Limited Corporation ☐ Corporation ☐ "S" Corporation

Is the sum of the following operations less than 25% of your total office payroll? ☐ Yes ☐ No ☐ 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 Full-Time	Part-Time	Estimated Annual Payroll	Average Hourly Wage	Estimated Annual Premium
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
			☐ Yes ☐ No	
			☐ Yes ☐ 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
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ 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: ____

1. Please provide a description of your business____
2. Is group medical insurance provided? ....☐ Yes ....☐ No Company ______________________________
   % Employees participate___________ % Paid by employer______________ If Blue Cross, Group # ________________
3. Do you have any volunteers/interns (working without pay)? ..☐ Yes......☐ No ......If yes, how many?________ Hours/Week________
4. Do you own, operate or lease an aircraft used in connection with your business? ☐ Yes ....☐ No
5. Do you have any other business operations? ....☐ Yes......☐ No ....If Yes, please describe ______________________
6. Do any employees work at home?............☐ Yes ....☐ No ....If yes, how many?_________ Hours/Week_________
   Address: ____
7. Is any work subcontracted to others?....☐ Yes ....☐ No ....If yes, are certificates of insurance obtained? ....☐ Yes ....☐ No
8. Hours of operation: _______ am. to _______ pm. Number of Shifts:__1__ (Indicate if more than 1)_____________
9. a. Do you have a return to light duty plan? ....☐ Yes ....☐ No
   b. Do you have a return to full time modified work plan? ......☐ Yes ....☐ No
10. Hiring Practices: a. Do you require a complete application?....☐ Yes ......☐ No..........b. Reference Checks? ....☐ Yes ..☐ No
    c. Motor Vehicle Record check? ....☐ Yes ......☐ No
11. Do you have: ...a written safety program? ....☐ Yes ....☐ No ....Incentive program? ....☐ Yes ..☐ No
    A safety director full-time? ....☐ Yes ....☐ No ....Are supervisors accountable for injuries/accidents?....☐ Yes ..☐ No
    Are safety meetings conducted for all employees? ☐ Yes ....☐ No ....How often?________________________________
    Is there a safety training program for employees? ..☐ Yes ....☐ No
12. Do your employees travel out of state for business? ....☐ Yes ......☐ No Frequency:______________________
    No. of employees traveling:__________________ Purpose:____
13. Gross receipts: % Wholesale:_________ % Retail:_________ Type of merchandise: ______________________________
    Is merchandise palletized? ..☐ Yes ..☐ No .....Is lifting or repackaging required? ...☐ Yes ..☐ No ... If yes, # lbs:____________________
    Is there assembly? ...☐ Yes ..☐ No ... If yes, what?____
14. Do you deliver?....☐ Yes ..☐ No .....Frequency: ..☐ Daily ..☐ Weekly ..☐ Other ....Number of vehicles:_____ Number of drivers:_____
    What is your delivery radius: ......☐ Less than 10 miles ......☐ 11–25 miles ....☐ 26–50 miles
    ☐ 51–100 miles ....☐ 101–250 miles ......☐ 250+ miles
    Do you have a vehicle maintenance program? ....☐ Yes ..☐ No ....How often do you inspect the vehicles?____________________
    Who completes the vehicle maintenance?..☐ Employees ☐ Others ..Do you have a Driver MVR "Pull" program? ....☐ Yes....☐ No
15. Do employees drive personal vehicles for business-related activities?.....☐ Yes .....☐ No
    Are driving records of such employees checked prior to hiring? ..☐ Yes......☐ No ......checked every 6 months? ....☐ Yes....☐ No
    Do you deliver products to clients via employee-owned vehicles..☐ Yes......☐ No ......If Yes, percentage of total delivery__________%
    Is there a written and enforced procedure to verify the existence and adequacy of the employee's auto insurance?..........☐ Yes....☐ No
16. What is the condition of your: <u>Premises</u>? ...☐ Excellent ...☐ Good ... ☐ Poor ....<u>Equipment</u>? ...☐ Excellent ...☐ Good ... ☐ Poor
17. Please provide estimated payroll for: 1st Year Prior $________________ 2nd Year Prior $________________
    3rd Year Prior $________________
18. What is your current Experience Modification Factor (if any)?__________%

APPLICATION CONTINUES ON PAGE 3

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, attn: Association Department
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

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Underwritten by:

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About Our Role and Compensation

The California Pharmacists Association has selected Fireman's Fund Insurance Company for this insurance program. Alternative insurance products may be available in the insurance market place. Marsh/Seabury & Smith Insurance Program Management is providing this single insurer option on behalf of the California Pharmacists Association. If the program requirements of the insurer are not met, Marsh may seek additional options on your behalf. In accordance with industry custom, we are compensated through commissions that are calculated as a percentage of the insurance premiums charged by insurers. We may also receive additional monetary and nonmonetary compensation from insurers, or from other insurance intermediaries, which may be contingent upon volume, profitability or other factors. This compensation may include payment from insurers for marketing related expenses or investments in technology. Our compensation may vary depending on the type of insurance purchased and the insurer selected. We will provide you additional information about our compensation and information about alternative quotes, upon your request. You may obtain this information by referring to https://www.personal-plans.com/disclosure and entering the security code O4235235 or call us at 1-888-206-5088 for specific details.