

# Workers' Compensation Premium Indication Form

4-157w

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:

Member Name: \_\_\_\_\_  
Pharmacy Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: CA Zip: \_\_\_\_\_  
Phone: (\_\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_\_) \_\_\_\_\_  
e-mail Address: \_\_\_\_\_ Contact: \_\_\_\_\_

## Workers' Compensation: *For information and a premium indication, please include the following:*

Present Workers' Compensation Carrier: \_\_\_\_\_ Policy Renewal Date: \_\_\_\_\_  
Present Business Owners Package Carrier: \_\_\_\_\_ Policy Renewal Date: \_\_\_\_\_  
Current Pharmacy Rate (Per \$100): \_\_\_\_\_  
Number of Employees: Full time \_\_\_\_\_ Part Time \_\_\_\_\_ Annual Employee Payroll: \$ \_\_\_\_\_  
Are any officers included in annual payroll above?.....  Yes.....  No  
If yes, to be excluded?.....  Yes.....  No..... If yes, exclude from above payroll: \$ \_\_\_\_\_  
If incorporated, do you wish coverage for yourself?  Yes  No **NOTE: All officers who do not own stock must be covered.**  
Years in Business \_\_\_\_\_  Individual  Partnership  Corporation  
 Joint Employers  Limited 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  
Is group medical insurance provided? ....  Yes .....  No Company: \_\_\_\_\_  
% of employees participate \_\_\_\_\_ % paid by employer \_\_\_\_\_ If Blue Cross, Group # \_\_\_\_\_  
Do you deliver? .. Yes .. No Frequency:.....  Daily .. Weekly .. Other # of Vehicles \_\_\_\_\_ # 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

## Signature:

I authorize Marsh to obtain a Workers' Compensation insurance premium indication(s) on my behalf:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Sponsored by:



Underwritten by:



Administered by:

**MARSH**

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