

California Workers' Compensation Program Application



FOR MEMBERS OF THE CMA/COUNTY MEDICAL ASSOCIATIONS AND SOCIETIES

101656w

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

EMPLOYER INFORMATION		Current Experience Modification Factor (if any): _____ %	
Member Name	CMA Membership #	Years in Business	Years of Experience
Practice Name	Practice Type/Specialty		
Address	Federal Employer ID#		
City	State CA	Zip	E-Mail Address
Phone ()	Fax ()	Practice Mode:	
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"/> Partnership <input type="checkbox"/> "S" Corporation <input type="checkbox"/> Corporation <input type="checkbox"/> Limited Corporation	
Is the sum of the following operations less than 25% of your total office payroll? <input type="checkbox"/> Yes <input type="checkbox"/> No			
• Urgent Care Clinics • Physical Therapy • Blood Donor/Drawing Centers • Non-Profit Pregnancy Termination Clinics			

EMPLOYEE PAYROLL INFORMATION				
Code #	Classification	# of Employees		Estimated Annual Payroll
		Full-Time	Part-Time	
8834	Physicians – all employees, including Clerical Office Employees – N.P.D.			
	Partners, Officers, Non-residing relatives to be covered			
	Average Hourly Wage	\$	\$	

Please provide estimated payroll for the past 3 years:

1st year prior: \$ _____ 2nd year prior: \$ _____ 3rd year prior: \$ _____

INDIVIDUAL Does the insured employ relatives? <input type="checkbox"/>					
Employed Relatives' Names	Age	Relationship	Residing With Insured?	Duties & Estimated Salary	Is Salary Included Above?
			<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

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%

*Only officers who own stock may be excluded.

Practice Name: _____

1. Is group medical insurance provided? Yes No Company _____
% Employees participate _____ % Paid by employer _____ If Blue Cross, Group # _____
2. Do you have any volunteers/interns (working without pay)? Yes .. No If yes, how many? _____ Hours/Week _____
3. Do you own, operate or lease an aircraft used in connection with your business? Yes No
4. Besides the physician office, do you have any other business operations?.... Yes No
If Yes, please describe _____
5. Do any employees work at home? Yes NoIf yes, how many? _____ Hours/Week _____
6. Is any work subcontracted to others? Yes NoIf yes, are certificates of insurance obtained? Yes No
If yes, what type of work is subcontracted? _____
Are subcontractors exclusive to your practice? Yes .. No
7. Do you have any Physical or Occupational Therapists on staff? 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
11. Do you have: ...a written safety program? Yes NoIncentive program? Yes .. No
A safety director full-time? Yes NoAre supervisors accountable for injuries/accidents?.... Yes .. No
Are safety meetings conducted for all employees? Yes NoHow often? _____
Is there a safety training program for employees? .. Yes NoCPR training? Yes .. No
12. Do your employees travel out of state for business? Yes No Frequency: _____
No. of employees traveling: _____ Purpose: _____
13. Do you perform surgical procedures? Yes NoIf Yes, please answer the following questions:
a. Where are the surgical procedures performed? (in the medical office, hospital, surgicenter, etc.) _____
b. When performing surgical procedures, do you utilize your office staff or the hospital staff? _____

THE LAST 3 YEARS OF LOSS RUNS FROM YOUR PREVIOUS INSURANCE CARRIER ARE REQUIRED. PLEASE ATTACH.

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 Mercer 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 Mercer to obtain a proposal on my behalf from the program insurers. They are authorized to release the name of my current insurer, pricing and policy terms. I will advise Mercer in writing if I do not want any of the above information released.

Officer's Signature: _____

Date: _____ **Completed by:** _____

Please email your completed application to: **LH.Admin@mercer.com**, fax it to: **515-365-0681**,
Or mail it to: **Mercer Health & Benefits Insurance Services**, P.O. Box 14438, Des Moines, IA 50306-9803
Questions? Please call a Client Advisor for help: **855-770-5257**

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About Our Role and Compensation

The California Medical Association/California County Medical Associations and Societies, Mercer clients, have selected Preferred Employers Insurance for this insurance program. Alternative insurance products may be available in the insurance market place. Mercer Health & Benefits Insurance Services LLC is providing this single insurer option on behalf of The California Medical Association/California County Medical Associations and Societies. 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 such factors as volume, growth or retention of business. 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 if applicable, 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 o4235233 or call us at 1-888-206-5088 for specific details.