Business Owners Package Premium Indication Request

MERCER
MAKE TOMORROW, TODAY

FOR MEMBERS OF THE CMA/COUNTY MEDICAL ASSOCIATIONS AND SOCIETIES 100671w

For more information complete the form below and fax to Mercer at: **515-365-0681,** or scan and e-mail it to **LH.Admin@mercer.com**

Member Information

Member Name:_____ M.D.

Practice Name:_____

Address:_____

City:_____ State: CA Zip:_____

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

E-Mail Address:_____ Contact:_____ Best time to call:_____

County Medical Association/Society:_____ How long have you owned your practice?_____

Business Owners Package *For a premium indication, please include the following information:*

Business Type ☐ Individual ☐ Corporation ☐ LLC ☐ Partnership ☐ Other (describe):_____

Limits ☐ $2 million/$4 million ☐ $1 million/$3 million Annual reciepts $ _____

Deductible options ☐ $500 ☐ $1,000 ☐ $2,500 ☐ $5,000

Number of full-time physicians:_____ Number of part-time physicians:_____

Number of employees full-time:_____ Number of employees part-time:_____

Current policy expiration date:_____ Current Carrier: _____

Any claims in the last 3 years? ☐ No ☐ Yes Business Personal Property $ _____

Check one ☐ Tenant ☐ Condo Owner ☐ Building Owner – Building Limit, if Owner: $ _____

Sprinklered ☐ No ☐ Yes Alarm ☐ No ☐ Yes Age of Building_____ Sq. ft. of building/office_____

Building Construction ☐ Frame ☐ Joisted Masonry ☐ Masonry Noncombustible ☐ Noncombustible ☐ Fire Resistive

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

Present Workers' Compensation Carrier: _____

Current Rate (Per $100):_____ Policy Renewal Date:_____

Number of Employees Full-time:_____ Part-time:_____ Annual Employee Payroll $_____

If incorporated, do you wish coverage for yourself or any other officers who own stock? ☐ No ☐ Yes

Do you provide Group Health Insurance? ☐ No ☐ Yes If Blue Cross, please provide Group # _____

Signature:

I authorize Mercer to obtain an Business Owners Package/Workers' Compensation insurance premium indication on my behalf:

Signature:_____ Date:_____

The insurance policy, not this letter, forms the contract between the insured and the insurance company. The policy may contain limits, exclusions, and limitations that are not detailed in this letter. Coverages may differ by state.