California Workers' Compensation Program Application

MERCER
MAKE TOMORROW, TODAY

FOR MEMBERS OF THE CMA/COUNTY MEDICAL ASSOCIATIONS AND SOCIETIES

100656e

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: ☐ Individual ☐ Joint Employers ☐ Partnership ☐ "S" Corporation ☐ Corporation ☐ Limited Corporation
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	

Is the sum of the following operations less than 25% of your total office payroll? ☐ Yes ☐ No

• Urgent Care Clinics • Physical Therapy • Blood Donor/Drawing Centers • Non-Profit Pregnancy Termination Clinics

EMPLOYEE PAYROLL INFORMATION

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

Please provide estmated payroll for the past 3 years:

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

INDIVIDUAL Does the insured employ relatives?

Employed Relatives' Names	Age	Relationship	Residing With Insured?	Duties & Estimated Salary	Is Salary Included Above?
			☐ Yes ☐ No		☐ Yes ☐ No
			☐ 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): ☐

*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 .....☐ No ....If yes, how many?_____ Hours/Week_____
6. Is any work subcontracted to others? ....☐ Yes .....☐ No ....If 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 ....☐ 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 .....CPR 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 .....☐ No .....If 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 mail the completed application to: **Mercer Health & Benefits Insurance Services, 777 S. Figueroa St., Los Angeles, CA 90017**

Or fax your application to:
213-346-5946

Questions? Please call a Client Advisor for help: **800-842-3761**
or e-mail us at: CMACounty.Insurance.service@mercer.com

Programs Administered by Mercer Health & Benefits Insurance Services LLC • CA Insurance License #0G39709 • 1-758 (4/17)
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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.