

California Optometric Association Sponsored  
**Business Owners Package Application**



How to request a quote or apply: complete this form, select the coverages you desire, and fax to 515-365-0681 or mail to Mercer, P.O. Box 14438, Des Moines, IA 50306-9803. Please print or type all information. If you would like assistance completing the form, call **800-775-2020**.

**1.) GENERAL APPLICANT INFORMATION** 300671w

Requested Effective Date: \_\_\_\_\_ Membership:  COA Member  Non-Member  
 Named Insured is:  Individual  Corporation  Partnership  Joint Venture  Other \_\_\_\_\_  
 Named Insured is:  Self Employed  Employee Optometrist  Independent Contractor  First Year Graduate \_\_\_\_\_ (Date Graduated) \_\_\_\_\_  
 If you are an Employee Optometrist, list name of employer \_\_\_\_\_

Business/Corporate Name, DBA, or Your Name, if not incorporated \_\_\_\_\_ Federal Tax I.D. # or Social Security # \_\_\_\_\_

Name of Owners, Partners, and Corporate Officers who are active in the business, their professional occupation and their social security numbers. \_\_\_\_\_

Street Address \_\_\_\_\_ Daytime Phone \_\_\_\_\_ Fax Number \_\_\_\_\_

City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

E-Mail Address \_\_\_\_\_

Location Address, if other than above: Please list additional locations on a separate sheet and attach. \_\_\_\_\_ Interest In Premises:  
 Street Address \_\_\_\_\_  Lessee  
 City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  Owner/Occupant  
 Owner/Lessor  
 Condo Owner

**2.) BUSINESS OWNERS PACKAGE**

Indicate limits of coverage you require in addition to the limits or coverages indicated below, for each location:

PROPERTY COVERAGES	LIABILITY COVERAGES		
Includes Business Income/Extra Expense — Actual Loss Sustained —	A separate policy must be issued for Professional Liability for the selected limits of liability.		
<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <p><b>Coverage A</b> Building \$ _____ Replacement Cost</p> <p>Deductible Per Policy:  <input type="checkbox"/> \$500 <input type="checkbox"/> \$1000 <input type="checkbox"/> \$2500 <input type="checkbox"/> \$5000</p> <p><b>Includes:</b>                      Accounts Receivable ..... \$25,000 or \$ _____                      Business Income – Up to 12 Months                      Valuable Papers ..... \$25,000 or \$ _____                      Personal Property Off Premises ..... \$2,500 or \$ _____</p> <p><b>Optional:</b>  <input type="checkbox"/> Computers and Media ..... \$10,000 or \$ _____</p> </td> <td style="width: 50%; vertical-align: top;"> <p><b>Coverage B</b> Contents \$ _____ Replacement Cost</p> </td> </tr> </table>	<p><b>Coverage A</b> Building \$ _____ Replacement Cost</p> <p>Deductible Per Policy:  <input type="checkbox"/> \$500 <input type="checkbox"/> \$1000 <input type="checkbox"/> \$2500 <input type="checkbox"/> \$5000</p> <p><b>Includes:</b>                      Accounts Receivable ..... \$25,000 or \$ _____                      Business Income – Up to 12 Months                      Valuable Papers ..... \$25,000 or \$ _____                      Personal Property Off Premises ..... \$2,500 or \$ _____</p> <p><b>Optional:</b>  <input type="checkbox"/> Computers and Media ..... \$10,000 or \$ _____</p>	<p><b>Coverage B</b> Contents \$ _____ Replacement Cost</p>	<p><b>Coverage C</b> — Business Liability Limits of Insurance  <input checked="" type="checkbox"/> \$2,000,000 per occurrence / \$4,000,000 annual aggregate</p> <p><b>Coverage D</b> — Medical Payments \$10,000 Per Person (included)</p> <p><b>Annual Receipts:</b> _____</p> <p><b>Includes:</b>                      Fire Legal Liability                      Tenant Glass Coverage – Up to \$25,000</p> <p><b>Optional:</b>  <input type="checkbox"/> Tenant’s Legal Liability (all perils)  <input type="checkbox"/> Employee Dishonesty  <input type="checkbox"/> Employee Benefits Liability \$10,000 or ... \$ _____  <input type="checkbox"/> Full Glass Coverage (Linear Feet) ..... _____ ft.  <input type="checkbox"/> Hired and Non-Owned Auto..... <input type="checkbox"/> Yes... <input type="checkbox"/> No  <input type="checkbox"/> Sewer and Drains</p>
<p><b>Coverage A</b> Building \$ _____ Replacement Cost</p> <p>Deductible Per Policy:  <input type="checkbox"/> \$500 <input type="checkbox"/> \$1000 <input type="checkbox"/> \$2500 <input type="checkbox"/> \$5000</p> <p><b>Includes:</b>                      Accounts Receivable ..... \$25,000 or \$ _____                      Business Income – Up to 12 Months                      Valuable Papers ..... \$25,000 or \$ _____                      Personal Property Off Premises ..... \$2,500 or \$ _____</p> <p><b>Optional:</b>  <input type="checkbox"/> Computers and Media ..... \$10,000 or \$ _____</p>	<p><b>Coverage B</b> Contents \$ _____ Replacement Cost</p>		

**Additional Insureds:**

- Loss Payee     Additional Named Insured
- Mortgagee     Leased Equipment Lessor

(If more than one, please provide name(s) and address(es) on a memorandum.)

Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Has the Insured agreed to name anyone as an Additional Insured?

ie: Landlord?     Yes     No

Additional Insured's interest: \_\_\_\_\_

(If more than one, please provide name(s), address(es) and interest on a memorandum.)

Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Prior Carrier Information — Business Owners**

Policy Term From/To	Insurance Company	Policy Number

Any policy or coverage declined, cancelled, non-renewed or placed in a non-standard market in the past 3 years?     Yes     No    If yes, explain.

**Loss Information (list all prior claims reported to carrier within 3 years — attach list if necessary)**

Include Property and Liability.     No prior losses in 3 years.

Loss Date	Description of Loss	\$ Amount Paid	\$ Reserve	Open	Closed

To the best of your knowledge are there any incurred but not reported claims?     Yes     No    If yes, explain.

**Complete This Section for Each Location**

**Construction:**

- Frame
- Joisted Masonry
- Non-Combustible
- Masonry Non-Combustible
- Modified Fire-Resistive
- Fire-Resistive

**Building Occupancy:**

- Single
- Multiple
- If multiple, list other occupants: \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**Is Building 75% Sprinklered?**

- Yes
- No

Total Bldg. Area: \_\_\_\_\_ Sq. Ft

Area Occupied by Insured: \_\_\_\_\_ Sq. Ft.

Basement(s): \_\_\_\_\_

Building • Year Building Built \_\_\_\_\_ • Number of Stories \_\_\_\_\_

**If building is more than 15 years old, have the wiring, plumbing and heating-A/C and/or roofing systems been partially or completely inspected, updated or replaced?**     Yes     No    If yes, provide the year updated or replaced:

Wiring: \_\_\_\_\_ Plumbing: \_\_\_\_\_ Heating: \_\_\_\_\_ Roof: \_\_\_\_\_ Comprehensive Renovation: \_\_\_\_\_

*Note: Comprehensive Renovation Year reflects when the building was gutted to the exterior walls and completely rebuilt with new interior walls, plumbing, heating, wiring and roof.*

**Protection**

- Number of fire extinguishers \_\_\_\_\_
- Smoke Detectors installed? .....  Yes     No  
 Hardwired? .....  Yes     No
- Burglar alarm? .....  Yes     No  
 Type:     local     silent     central station
- Fire alarm? .....  Yes     No  
 Type:     local     silent     central station

**Management**

- Year this business started \_\_\_\_\_ Year
- Total number of employees: \_\_\_\_\_ Full Time  
 \_\_\_\_\_ Part Time

### 3.) PROVIDER CONTRACTS

- |   |                                      |
|---|--------------------------------------|
| <input type="checkbox"/> Vision Service Plan        | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> AVP                        | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Cole Vision                | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Davis Vision               | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Block Vision               | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Medical Eye Services (MES) | <input type="checkbox"/> Other _____ |

### 4.) SIGNATURE

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 Business Owners Package insurance policies solely for the purpose of obtaining 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 Mercer in writing if I do not want any of the above information released.

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



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800-775-2020 • COA.Insurance.service@mercer.com • www.COAMemberInsurance.com

#### About Our Role and Compensation

Mercer Health & Benefits Insurance Services LLC (Mercer) facilitates the placement of insurance coverage on behalf of our clients. 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 information about alternative quotes, upon your request. You may obtain this information by calling 800-775-2020.

In this transaction, Mercer is paid a standard commission of the insurance premium for this placement. We may also earn contingent commission on this transaction. For more information on contingent commission amounts received by Mercer, please call 800-775-2020 and request information about the Bonus Commissions. Where permitted by law, Mercer may also earn and retain interest income on premiums held by Mercer on behalf of insurers during the period between receipt of such payments from clients and the time such payments are remitted to the applicable insurer. If you utilize premium financing, additional fees may also be earned which will be disclosed at the time premium financing is offered.

Marsh & McLennan Companies, Inc. and its subsidiaries which include Mercer own equity interests in certain insurers and wholesale brokers. Information regarding such interests is available at [www.mercer.com/transparency](http://www.mercer.com/transparency). Information on material ownership, if any, that a quoting insurer has in Marsh & McLennan Companies or its subsidiaries is available upon request.

Mercer Health & Benefits Insurance Services LLC is prohibited by law in most states from altering the amount of compensation received from the insurer based in whole or in part on the sale of this insurance<sup>1</sup>.

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