

Optometry Owners Package Premium Indication Form

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Sponsored by the California Optometric Association. For more information complete the form below and fax to Mercer at 515-365-0681. Or scan and e-mail to LH.Admin@mercer.com

Member Information

Member Name _____

Practice Name _____

Address _____

City _____ State _____ ZIP _____

Phone (_____) _____ Fax (_____) _____

E-mail Address _____ Contact _____ Best time to call _____

How long have you owned your practice? _____

Is your practice in a retail store?(e.g., Sears, Walmart, etc.) If so, name of store _____

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

Business type: Individual Corporation Partnership Other (describe) _____

Limits: \$2 million/\$4 million

Deductible options: \$500 \$1,000 \$2,500 \$5,000

Annual receipts _____

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

Current policy expiration date _____ Current carrier _____

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

Check one: Tenant Condo owner Building owner—Building limit if owner \$ _____

Square footage of office _____ Number of stories _____

Occupancy: Single Multiple If multiple, list other occupants _____

Sprinklered: Yes No Alarm: Yes No Year building built _____ If renovated, year _____

Building construction: Frame Joisted Masonry Masonry Noncombustible

Noncombustible Fire Resistive

Exterior glass coverage needed? Yes No If "Yes," linear feet of glass _____ ft

Signature

I authorize Mercer to obtain a Optometry Owners Package insurance premium indication(s) on my behalf:

Signature **X** _____ Date **X** _____

Sponsored by:



Administered by:



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.

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