

California Optometric Association Sponsored Workers' Compensation Program Application

3-658w

Check one: Please issue a quote Please consider this application as a request for coverage

Policy period : From: _____ To: February 1, 20_____. At 12:01 a.m. Pacific Standard Time as to each of said dates.

EMPLOYER INFORMATION	
Employer Name (including DBA)	<input type="checkbox"/> Association Member <input type="checkbox"/> Non-Member
Address	Years in Practice
City State CA Zip	Years in Business / At this location?
Phone () Fax ()	Federal Employer ID#
E-mail Address	<input type="checkbox"/> Individual <input type="checkbox"/> Joint Employers
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"/> Partnership <input type="checkbox"/> Limited Corporation
	<input type="checkbox"/> Corporation <input type="checkbox"/> "S" Corporation

EMPLOYEE INFORMATION						
Code #	Classification	# of Employees		Estimated Annual Payroll	Rate Per \$100	Estimated Annual Premium
		Full-Time	Part-Time			
8834	Optometrists - all employees, including Clerical Office Employees - N.P.D.					
	Partners, Officers, Non-residing relatives to be covered					
Total						

INDIVIDUAL				
Employed Relatives' Names	Age	Relationship	Residing With Insured?*	Duties & Estimated Salary
			<input type="checkbox"/> Yes* <input type="checkbox"/> No	
			<input type="checkbox"/> Yes* <input type="checkbox"/> No	

* Residing relatives cannot be covered

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%

Employer Name/DBA: _____

1. Please list your previous carrier information for the past 3 years below. **Attach claims history for each of the companies listed.** (This information is required to approve your coverage.)

PREVIOUS INSURANCE CARRIER – Last 3 years experience required.						
Previous Carrier	Policy Number	Period	Premium	Losses (Please describe in detail below)	Valued Date	Loss Ratio

- a. If a new venture, number of years prior experience: _____ b. Number of years licensed: _____
c. Any prior ownership and/or management experience:.... Yes.... No....If yes, please explain:

2. Has any prior coverage been declined/cancelled/non-renewed in the last 4 years? Yes No (Provide details on separate sheet)
3. Do you have any volunteers/interns (working without pay)? Yes No
4. Do you own, operate or lease an aircraft used in connection with your business? Yes No
If yes, please provide the following information:
How many seats? _____ Are employees transported? Yes No Is the pilot an employee? Yes No

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 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.

Officer's Signature: _____ **Date:** _____

Completed by: _____ (Applications are subject to underwriting and approval.)

Fax your completed application to: 213-346-5946

Or mail to: Mercer, attn: Association Department,
777 S. Figueroa St., Los Angeles, CA 90017

For more information, or assistance completing this form, call: 800-775-2020.

Producer:



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About Our Role and Compensation

The California Optometric Association has selected ZNAT Insurance Company (Zenith) 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 Optometric Association. If the program requirements of the insurer are not met, Mercer may seek additional options on your behalf. 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 volume, profitability or other factors. 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 referring to <https://www.personal-plans.com/disclosure> and entering the security code O4235234 or call us at 1-888-206-5088 for specific details.