

Workers' Compensation Insurance Premium Indication Request



FOR MEMBERS OF THE CALIFORNIA OPTOMETRIC ASSOCIATION

300656w

For more information complete the form below and fax to Mercer at: 515-365-368, or scan and e-mail to: LH.Admin@mercer.com

Member Information

Member Name: _____
Practice Name: _____
Address: _____
City: _____ State: CA Zip: _____
Phone: (_____) _____ Fax: (_____) _____
e-mail Address: _____ Contact: _____

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

Present Workers' Compensation Carrier _____
Current Rate (Per \$100) _____ Policy Renewal Date _____
Number of Employees: Full-Time _____ Part-Time _____ Annual Employee Payroll \$ _____
Are any officers/partners included in annual payroll above?..... Yes..... No
If "Yes," to be excluded?..... Yes..... No..... If "Yes," exclude from above payroll: \$ _____
If incorporated, do you wish coverage for yourself? Yes No **NOTE: All officers who do not own stock must be covered.**
Years in Business _____ Individual Partnership Corporation
 Joint Employers Limited Corporation "S" Corporation
Is group medical insurance provided? Yes No If Blue Cross, Group # _____

Additional Programs

Please send me information on these additional sponsored programs:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Medical | <input type="checkbox"/> High Deductible Health Plans (for HSAs) | <input type="checkbox"/> Professional Liability | <input type="checkbox"/> Long Term Disability |
| <input type="checkbox"/> Individual | <input type="checkbox"/> PPO | <input type="checkbox"/> Business Owners Package | <input type="checkbox"/> Business Overhead Expense |
| <input type="checkbox"/> Small Group (2-50) | <input type="checkbox"/> HMO | <input type="checkbox"/> Cyber Liability | <input type="checkbox"/> Dental |
| <input type="checkbox"/> Large Group (51+) | | <input type="checkbox"/> Level Term Life | <input type="checkbox"/> Auto & Home |
| | | <input type="checkbox"/> Long Term Care | |

Signature:

I authorize Mercer to obtain a Workers' Compensation insurance premium indication(s) on my behalf:

Signature: _____ Date: _____

Sponsored by:



Underwritten by:



Administered by:

