Business Owners Package Premium Indication Request

Mercer

FOR MEMBERS OF THE CALIFORNIA PHARMACISTS ASSOCIATION 400671w

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_____

Pharmacy Name_____

Address_____

City_____ State CA Zip_____

Phone (_____)_____ Fax (_____)_____

e-mail Address_____ Contact_____

How long have you owned your pharmacy?_____

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

Business Type ☐ Individual ☐ Corporation ☐ LLC ☐ Partnership ☐ Other (describe)_____

Pharmacy Type ☐ Community Pharmacy ☐ Closed Door Pharmacy ☐ Other_____

Limits ☑ $2 million/$4 million ☑ Include expanded Pharmacy Services wording

Annual Prescription Drug Receipts $_____ Number of Scripts filled daily_____

Number of full-time pharmacists _____ Number of full-time technicians_____

Current policy expiration date _____ Current Carrier _____

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

Check one ☐ Tenant ☐ Building Owner – Building Limit, if Owner: $_____

Sprinklered ☐ No ☐ Yes Alarm ☐ Central ☐ Local Age of Building_____

Building Construction ☐ Frame ☐ Joisted Masonry ☐ Masonry Noncombustible ☐ Noncombustible ☐ Fire Resistive

Signature

This is not an application for insurance.

I authorize Mercer to obtain a Business Owners Package premium indication(s) on my behalf.

Signature X_____ Date X_____

Sponsored by: california pharmacists association

Administered by: Mercer

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.