# California Pharmacists Association Sponsored
# California Workers' Compensation Program Application

400656w

Proposed Effective Date: From:_____ To:_____. At 12:01 a.m. Pacific Standard Time as to each of said dates.

## EMPLOYER INFORMATION

Mercer Sales Associate / Sub-Producer:_____

| | |
|---|---|
| Applicant Name | Years in Practice as a Pharmacist |
| Entity Name | Years in Business as a Pharmacy Owner |
| DBA | Years at this Location |
| Address | Billing ☐ Annual ☐ Semi-Annual ☐ Quarterly |
| City State CA Zip | Federal Employer ID# |
| Phone ( ) Fax ( ) | E-mail Address |
| Do you have Additional Locations? ☐ Yes ☐ No – If yes, please list each location on page 2. | Entity Type: ☐ Individual ☐ Joint Employers ☐ Partnership ☐ LLC ☐ Corporation ☐ "S" Corporation |
| ☐ Community Pharmacy ☐ Closed Door Pharmacy ☐ Long Term Care ☐ Other *(please specify)*: | |

Is the sum of the following operations less than 25% of your total office payroll? ☐ Yes ☐ No ☐ N/A

• Health Care Screenings • Nursing Activities • Home Health Care • Deliveries *(Except Closed Door Pharmacies)* • Heavy DME Rental & Delivery

## EMPLOYEE INFORMATION

| Code # | Classification | Total # of Employees for **ALL** locations Full-Time | Part-Time | Total Estimated Annual Payroll for **ALL** locations |
|---|---|---|---|---|
| 8017 | Pharmacies Stores – Retail – NOC | | | |
| | Partners, Officers, Non-residing relatives to be covered | | | |
| 8810 | Clerical Office Employees | | | |
| 8742 | Salesperson - Outside Sales | | | |
| | Other | | | |

## INDIVIDUAL — Section to be completed if the ENTITY is an Individual

| Employed Relatives' Names | Age | Relationship | Residing With Insured? | Duties | Estimated Salary |
|---|---|---|---|---|---|
| | | | ☐ Yes ☐ No | | |
| | | | ☐ Yes ☐ No | | |

## CORPORATION

| Name of Officer/Director | Title | % Stock Owned | To be Covered? | Signature of Officer/Director |
|---|---|---|---|---|
| | | | ☐ Yes ☐ No | |
| | | | ☐ Yes ☐ No | |
| | | | ☐ Yes ☐ No | |

## PARTNERSHIPS AND LLCs

| Name of General Partner or Managing Member | Title | To be Covered? | Signature of General Partner or Managing Member |
|---|---|---|---|
| | | ☐ Yes ☐ No | |
| | | ☐ Yes ☐ No | |

1. Additional Covered Locations (if any):

   Location #2:_____

   Location #3:_____

2. Is group medical insurance provided? .....☐ Yes.....☐ No Company: _____
   % Employees participate:_____ % Paid by employer:_____ If Blue Cross, Group #:_____

3. Do you have any volunteers/interns (working without pay)? ..☐ Yes ....☐ No .....If yes, how many?_____ Hours/Week:_____

4. Do you own, operate or lease an aircraft used in connection with your business? ☐ Yes.....☐ No

5. Do you have any other business operations? ....☐ Yes ....☐ No .....If Yes, please describe:_____

6. Do any employees work at home?.....☐ Yes.....☐ No ....If yes, how many?_____ Hours/Week:_____
   Address: _____

7. Is any work subcontracted to others?....☐ Yes.....☐ No ....If yes, are certificates of insurance obtained? .....☐ Yes.....☐ No

8. Hours of operation: _____ am. to _____ pm. Number of Shifts:1 (Indicate if more than 1):_____

9. Do you have: ...a written safety program?.....☐ Yes ....☐ No.....Incentive program?.....☐ Yes ..☐ No
   A safety director full-time?.....☐ Yes ....☐ No.....Are supervisors accountable for injuries/accidents?....☐ Yes ..☐ No
   Are safety meetings conducted for all employees? ☐ Yes ....☐ No.....How often?_____
   Is there a safety training program for employees? ..☐ Yes ....☐ No

10. Do your employees travel out of state for business? .....☐ Yes .....☐ No Frequency:_____
    No. of employees traveling:_____ Purpose:_____

11. Do you deliver?....☐ Yes ..☐ No .....Frequency: ..☐ Daily ..☐ Weekly ..☐ Other ....Number of vehicles:_____ Number of drivers:_____
    If yes, percent of time drivers spend delivering:_____%
    What is your delivery radius: .....☐ Less than 10 miles .....☐ 11–25 miles .....☐ 26+ miles
    Do you have a vehicle maintenance program? ....☐ Yes ..☐ No .....How often do you inspect the vehicles?_____
    Who completes the vehicle maintenance?..☐ Employees ☐ Others ..Do you have a Driver MVR "Pull" program? .....☐ Yes ..☐ No

12. Do employees drive personal vehicles for business-related activities?.....☐ Yes .....☐ No
    Are driving records of such employees checked prior to hiring? ..☐ Yes ....☐ No .....checked every 6 months? .....☐ Yes ..☐ No
    Do you deliver products to clients via employee-owned vehicles..☐ Yes ....☐ No .....If Yes, percentage of total delivery:_____%
    Is there a written and enforced procedure to verify the existence and adequacy of the employee's auto insurance? .....☐ Yes ..☐ No

13. What is your current Experience Modification Factor (if any)?_____%

14. 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) |
| | | | | |
| | | | | |
| | | | | |

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

_____

_____

20. Has any prior coverage been declined/cancelled/non-renewed in the last 4 years? .....☐ No ....☐ Yes (Provide details on separate sheet)

***APPLICATION CONTINUES ON PAGE 3***

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:**_____

**To Be Completed by Agent:**

**Producer's Signature:** _____ **Agent Name:**_____

**Producing Retail Agency** *(if not Mercer)*:_____ **Tax ID #:** _____

**Agent Address:** _____ **Phone: (_____)** _____

**City, State, Zip:**_____ **Code:** _____

## About Our Role and Compensation

The California Pharmacists Association, a Mercer client, has selected Preferred Employers Group 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 Pharmacists Association. 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 if applicable, 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 06772249 or call us at 1-888-206-5088 for specific details.

Please email your completed application to: **LH.Admin@mercer.com,** fax it to: **515-365-0681,**
Or mail it to: **Mercer Health & Benefits Insurance Services,** P.O. Box 14438, Des Moines, IA 50306-9803

**Questions?** Please call a Client Advisor for help: **888-926-CPhA**

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