Workers' Compensation Insurance Premium Indication Request

MERCER
MAKE TOMORROW, TODAY

FOR MEMBERS OF THE CALIFORNIA PHARMACISTS ASSOCIATION

400656w

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: _____

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

Present Workers' Compensation Carrier: _____

Policy Renewal Date: _____ Current Pharmacy Rate (Per $100): _____

Number of Employees: Full time_____ Part Time_____ Annual Employee Payroll: $ _____

Are any officers 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 <u>not</u> own stock <u>must</u> be covered.**

Years in Business _____ ☐ Individual ☐ Partnership ☐ Corporation
☐ Joint Employers ☐ Limited Corporation ☐ "S" Corporation

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

Is group medical insurance provided? .... ☐ Yes ..... ☐ No Company: _____

Do you deliver? ..☐ Yes ..☐ No Frequency:.... ☐ Daily ..☐ Weekly ..☐ Other # of Vehicles_____ # of Drivers:_____
If yes, percent of time drivers spend delivering:_____%

Additional Programs

Please send me information on these additional sponsored programs:

☐ Medical: ☐ Individual ☐ Small Group (2 – 50) ☐ Large Group (51+)

☐ Long Term Disability ☐ Long Term Care ☐ Level Term Life

☐ Business Owners Package ☐ Professional Liability ☐ Auto & Homeowners

Signature:

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

Signature: _____ Date: _____

Sponsored by: california pharmacists association

Underwritten by: PREFERRED EMPLOYERS Insurance | a Berkley Company

Administered by: MERCER MAKE TOMORROW, TODAY

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