California Pharmacists Association Sponsored
California Workers' Compensation Program Application

401656e

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

EMPLOYER INFORMATION

AMBA 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 AMBA 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 AMBA 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 AMBA 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 AMBA)*:_____ **Tax ID #:** _____

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

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

Please email your completed application to: LH.Admin@getamba.com,
Or mail it to: Association Member Benefits & Insurance Agency, P.O. Box 5256, Des Moines, IA 50306

Questions? Please call a Client Advisor for help: 1-888-926-CPhA

Sponsored by: california pharmacists association

Underwritten by: Preferred Employers Insurance | a Berkley Company

Administered by: AMBA

Program Administered by Association Member Benefits & Insurance Agency • CA Insurance License #0I96562

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