

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 <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly	
City	State CA Zip	Federal Employer ID#	
Phone ()	Fax ()	E-mail Address	
Do you have Additional Locations? <input type="checkbox"/> Yes <input type="checkbox"/> No – If yes, please list each location on page 2.		Entity Type: <input type="checkbox"/> Individual <input type="checkbox"/> Joint Employers <input type="checkbox"/> Partnership <input type="checkbox"/> LLC <input type="checkbox"/> Corporation <input type="checkbox"/> "S" Corporation	
<input type="checkbox"/> Community Pharmacy <input type="checkbox"/> Closed Door Pharmacy <input type="checkbox"/> Long Term Care <input type="checkbox"/> Other (please specify):			
Is the sum of the following operations less than 25% of your total office payroll? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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		Total Estimated Annual Payroll for ALL locations
		Full-Time	Part-Time	
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
			<input type="checkbox"/> Yes <input type="checkbox"/> No		
			<input type="checkbox"/> Yes <input type="checkbox"/> No		

CORPORATION				
Name of Officer/Director	Title	% Stock Owned	To be Covered?	Signature of Officer/Director
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	

PARTNERSHIPS AND LLCs			
Name of General Partner or Managing Member	Title	To be Covered?	Signature of General Partner or Managing Member
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> 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 NoIf 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 NoIf Yes, please describe: _____

6. Do any employees work at home?..... Yes..... NoIf yes, how many? _____ Hours/Week: _____

Address: _____

7. Is any work subcontracted to others? Yes..... NoIf 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 NoIncentive program? Yes .. No

A safety director full-time? Yes NoAre supervisors accountable for injuries/accidents?.... Yes .. No

Are safety meetings conducted for all employees? Yes NoHow 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 .. NoFrequency: .. Daily .. Weekly .. OtherNumber 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 .. NoHow 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 Nochecked every 6 months? Yes .. No

Do you deliver products to clients via employee-owned vehicles.. Yes NoIf 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)

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: _____

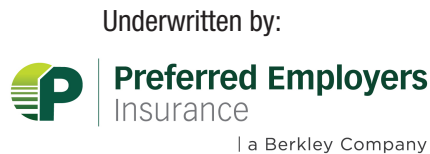
Producing Retail Agency (if not AMBA): _____ Tax ID #: _____

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



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