

Workers' Compensation Premium Indication Form

Sponsored by the State Bar of California

Fax this form to: **213-346-5946** or call: **877-446-7492**

Member Information:

Member Name: _____

Firm Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____ Fax: (_____) _____

E-mail Address: _____ Contact: _____

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

Present Workers' Compensation Carrier: _____

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

Number of Employees: Full time _____ Part Time _____ Annual Employee Payroll: \$ _____

Are any officers/partners 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 not own stock must be covered.**

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

Is group medical insurance provided? Yes No Company: _____

% of employees participate _____ % paid by employer _____ If Blue Cross, Group # _____

Additional Programs:

Please send me information on these additional sponsored programs:

Professional Liability Term Life: 10-Year Term 20-Year Term Annual Renewable Term

Business Owners Package Group Accidental Death & Dismemberment

Signature:

I authorize Marsh to obtain a Workers' Compensation insurance proposal from the State Bar sponsored Workers' Compensation carrier on my behalf.

Signature: _____ Date: _____

Sponsored by:



Underwritten by:



Administered by:

MARSH

MMC MARSH MERCER KROLL
GUY CARPENTER OLIVER WYMAN

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