California Optometric Association Sponsored Workers' Compensation Program Application

TheZenith
A FAIRFAX Company
Zenith Insurance Company
ZNAT Insurance Company

Check one: ☐ Please issue a quote ☐ Please consider this application as a request for coverage

300656w

Policy period : From:_____ To: February 1, 20_____. At 12:01 a.m. Pacific Standard Time as to each of said dates.

EMPLOYER INFORMATION

Employer Name (including DBA)	☐ Association Member ☐ Non-Member
Address	Years in Practice
City State CA Zip	Years in Business / At this location?
Phone ( ) Fax ( )	Federal Employer ID#
E-mail Address	☐ Individual ☐ Joint Employers ☐ Partnership ☐ Limited Corporation ☐ Corporation ☐ "S" Corporation
Do you have Additional Locations? ☐ Yes ☐ No – If yes, please list each location on a separate page with payroll and number of full-time and part-time employees at each.	

EMPLOYEE INFORMATION

Code #	Classification	# of Employees Full-Time	# of Employees Part-Time	Estimated Annual Payroll	Rate Per $100	Estimated Annual Premium
8834	Optometrists – all employees, including Clerical Office Employees – N.P.D.					
	Partners, Officers, Non-residing relatives to be covered					

Total

INDIVIDUAL OR SOLE PROPRIETOR

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

* Residing relatives cannot be covered

CORPORATION OR PARTNERSHIP

Name of Officer/Director or General Partner	Title	% Stock Owned (Corp. Only)	To be Covered?	*Signature of Officer/Director or General Partner if NOT Covered
			☐ Yes ☐ No*	
			☐ Yes ☐ No*	
			☐ Yes ☐ No*	
			☐ Yes ☐ No*	
			☐ Yes ☐ No*	

Ownership Must Total 100% (Corporations Only): 100%

Employer Name/DBA: _____

1. 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 of Loss Runs/Claims History REQUIRED.						
Previous Carrier	Policy Number	Period	Premium	Losses (Please describe in detail below)	Valued Date	Loss Ratio

a. If a new venture, number of years prior experience:_____ b. Number of years licensed:_____

c. Any prior ownership and/or management experience:...☐ Yes...☐ No....If yes, please explain:

_____

_____

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

3. a. Do you have any volunteers/interns (working without pay)?...☐ Yes...☐ No b. Do you use any sub-contractors?...☐ Yes...☐ No
c. Are any employees leased?...☐ Yes...☐ No

4. Do you own, operate or lease an aircraft used in connection with your business?...☐ Yes...☐ No....If yes, please provide the following information:
How many seats?_____ Are employees transported?...☐ Yes...☐ No Is the pilot an employee?...☐ Yes...☐ No

5. Do employees perform work for other businesses or subsidiaries?...☐ Yes...☐ No

6. Have you had any tax liens or bankruptcy within the last 5 years?...☐ Yes...☐ No

7. Do you have any undisputed and unpaid workers' compensation premiums due from any commonly managed or owned enterprises?...☐ Yes...☐ No

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:_____ (Applications are subject to underwriting and approval.)

Fax your completed application to: 515-365-0681

Or mail to: AMBA, P.O. Box 5256
Des Moines, IA 50306

For more information, or assistance completing this form, call: 800-775-2020.

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