Societies Insurance
Phone: 800-616-3490
East Coast: 706-550-4418
West Coast: 206-755-0101
Internet: www.societiesinsurance.com
Email: info@societiesinsurance.com

Societies Insurance

CALCHOICE SUPPLEMENTAL APPLICATION

Please answer all questions. Attach additional sheets if more space is needed.

SECTION I. APPLICANT INFORMATION

1. Proposed Effective Date: _____ To _____
2. Named Insured – business / entity name (full legal name, e.g. "ABC Plumbing, LLC"): _____
3. DBA / Trade name(s): _____
4. Physical street address: _____
5. City: _____ County: _____ State: _____ Zip Code: _____
6. Is the mailing address different from the physical address? ☐ Yes ☐ No
   Mailing Address: _____
   City: _____ State: _____ Zip Code: _____
7. Contact Person – your first and last name: _____
   Title (owner, manager, partner, etc.): _____
8. Primary phone: _____ ☐ Cell ☐ Business ☐ Home
9. Secondary phone (optional): _____ ☐ Cell ☐ Business ☐ Home
10. Primary email: _____
    Secondary email (optional): _____
11. Do you have a website? ☐ Yes ☐ No
    Website: _____
12. FEIN: _____ Year business started: _____ Years of industry experience: _____
13. Type of entity
    ☐ Individual / sole proprietor ☐ Partnership ☐ Corporation
    ☐ LLC ☐ Nonprofit ☐ Other

SECTION II. BUSINESS OPERATIONS

14. Describe your operations in detail: _____
15. Additional description: _____
16. Annual revenue - last 12 months: $ _____ Next 12 months: $ _____
17. Full-time employees: _____ Part-time employees: _____ Annual payroll: $ _____
18. Occupied area (square feet): _____
19. Other locations, if any (location 1 is the physical address above; if more than three, attach an additional schedule):

Street Address	City	County	State	Zip Code

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SECTION III. CALCHOICE

20. Eligible employees: _____ Expected to enroll: _____ Waiving with other coverage: _____
21. Minimum hours per week to be eligible: _____
22. Is the business's principal office in California? ☐ Yes ☐ No
23. Percentage of eligible employees who live in California: _____
24. Does the business carry active workers' compensation coverage? ☐ Yes ☐ No
25. Employer contribution toward the lowest-cost medical plan
    ☐ 50% ☐ 51-75% ☐ 76-99% ☐ 100%
26. Will you contribute toward dependent premiums? ☐ Yes ☐ No
27. Add dental coverage? ☐ Yes ☐ No
28. Add vision coverage? ☐ Yes ☐ No
29. Add chiropractic and acupuncture coverage? ☐ Yes ☐ No
30. Add group life and AD&D coverage? ☐ Yes ☐ No
31. Current carrier and plan: _____ Renewal date: _____
32. Is the group currently enrolled with CaliforniaChoice? ☐ Yes ☐ No
33. Are any employees currently covered by Health Net? ☐ Yes ☐ No
34. Is an employee census attached (age, ZIP code, coverage tier)? ☐ Yes ☐ No
35. Is the most recent quarterly wage report (DE 9C) attached? ☐ Yes ☐ No
36. Are any former employees or dependents on COBRA or Cal-COBRA? ☐ Yes ☐ No

SECTION IV. COVERAGE REQUESTED

37. Limits and coverages requested: _____
38. Other coverage or limits requested: _____

SECTION V. PRIOR INSURANCE

39. List current and prior insurance (last 3 years):

Policy Year	Insurance Company	Coverage	Limits	Premium

☐ If no prior insurance, check here (no prior insurance)

40. Current policy expiration date: _____
    a. If you currently have insurance, or had it in the past 12 months, what is the approximate premium for that policy / coverage? $ _____ ☐ per year ☐ per month
    b. Do you have a target premium for this upcoming policy / coverage? ☐ Yes ☐ No
       If yes, target premium: $ _____ ☐ per year ☐ per month

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SECTION VI. LOSS HISTORY

41. Any claims, lawsuits, demands or losses in the past 5 years (insured or not)? ☐ Yes ☐ No

    If yes, explain: _____

42. Has any insurer cancelled, declined or non-renewed coverage for you in the past 3 years? ☐ Yes ☐ No

    If yes, explain: _____

43. Are you aware of any incident or circumstance that could give rise to a claim? ☐ Yes ☐ No

    If yes, explain: _____

44. List all claims in the past five (5) years (attach currently valued loss runs):

Date of Loss	Type of Loss	Description	Amount Paid	Status (O/C)

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Fraud Warnings:
Please refer to Acord 63 for state specific fraud warnings: This application cannot be considered complete until the signed ACORD 63 fraud warning statement has also been attached.

Fraud warning: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing materially false information may be guilty of a criminal offense and may be subject to fines and confinement in prison, and denial of insurance benefits.

WARRANTIES AND REPRESENTATIONS

In submitting this application, the undersigned warrants and represents that:

a) The information in this application and all attachments is true and complete as of the date submitted;
b) The insurer may, and is intended to, rely upon such information in determining whether to issue coverage and, if so, at what premium and upon what terms;
c) Upon any change in circumstances which bears upon the accuracy or completeness of the undersigned's representations herein prior to binding, he/she shall notify the insurer in writing and such notice shall become a part of this application;
d) The insurer may change the quoted premium and/or the terms of any coverage if, subsequent to the submission of this application, it becomes aware of any such circumstances, whether by notice from the undersigned or otherwise;
e) The undersigned authorizes the insurer and its agents to obtain information regarding the applicant's prior insurance, claims history, loss runs and, where permitted by law, motor vehicle and credit reports; and
f) The submission of this application shall not bind the insurer or its agents to the issuance of insurance coverage, nor shall it bind the undersigned to accept insurance coverage.

Applicant Name (Required)	Applicant Signature (Required)	Title (Required)	Date (Required)

Applicant Phone (Required)	Applicant Email (Required)

Producer Name (Required)	Producer Signature (Required)	Date (Required)

Producer Phone (Required)	Producer Email (Required)	State License # (Required)	Producer NPN (Required)
800-616-3490	info@societiesinsurance.com		

Producing Agency	Agency NPN
Societies Insurance (in CA: DBA Cavlogix Insurance Agency)	16247324