PHARMACIES/PHARMACISTS PROFESSIONAL LIABILITY AND GENERAL LIABILITY INSURANCE APPLICATION—CLAIMS MADE AND REPORTED BASIS

Desired effective date: _____

1. Complete name of applicant (if other than parent firm, supply full details of ownership entity; attach an additional sheet if necessary):

   _____

   Address: _____

   City: _____ State: _____ County: _____ ZIP: _____

   Contact Name: _____ Title: _____

   Contact Email Address: _____ Phone: _____

   Website URL: _____

   List all other locations:

2. Applicant is:
   a. ☐ Individual ☐ Partnership ☐ Corporation ☐ Professional Association ☐ Other: _____
   b. ☐ Not-for-Profit ☐ For-Profit ☐ Both
3. Date established: _____
4. OPERATIONS
   a. Describe the nature of applicant's operations including types and percentage of services rendered **(must total 100%):**

Operation and description	Percentage
Retail:	%
Wholesale:	%
Mail Order:	%
Drug Benefit:	%
Compounding:	%
Other (specify):	%

   b. Provide the following information for all of the states in which you are licensed (attach an additional sheet if necessary):

State	License Number	Effective Date	Expiration Date

   c. Are all drugs dispensed FDA approved? ☐ Yes ☐ No
   If no, attach an explanation.

d. Are any drugs imported? ☐ Yes ☐ No
If yes, attach an explanation.
e. Does a licensed physician in the state where services are rendered issue all prescriptions? ☐ Yes ☐ No
f. Is pharmacy in compliance with all local, state and federal laws that govern the manufacture, control, dispensing and distribution of prescription drugs? ☐ Yes ☐ No
g. Annual number of prescriptions filled: _____
h. Annual gross receipts (complete all applicable categories):

	Last 12 Months	Next 12 Months
From Prescription Sales	$	$
From Sundries Sales	$	$
From Medical Equipment Sales	$	$
From Medical Equipment Rental	$	$
From In-Home Therapy	$	$
Other (specify):	$	$
TOTAL	**$**	**$**

5. PROFESSIONAL SERVICES
a. Do you provide mail order services? ☐ Yes ☐ No
If yes, attach details of safety controls to assure a licensed physician authorizes prescriptions.
b. Do you provide services to any of the following?
☐ Nursing Homes ☐ Hospitals ☐ Extended Care Facilities ☐ Correctional Facilities ☐ MCOs
If yes, attach a copy of contract.
c. Do you provide Pharmacy Benefit Management services, including any of the following: drug utilization review, formulary management and design, medical necessity review, credentialing review, pharmacy data and supporting services? ☐ Yes ☐ No
If yes, attach list of five (5) largest clients and provide a copy of sample contract.
d. Do you compound in bulk, manufacture or wholesale drugs or products? ☐ Yes ☐ No
If yes, are active ingredients purchased from chemical factories that have registered with the FDA? ☐ Yes ☐ No
e. Are you a member of the Institute for Safe Medication Practices (ISMP)? ☐ Yes ☐ No
f. Please indicate the type of medical supplies and/or equipment you sell or lease or repair for others:

Type of Supplies and/or Equipment	Annual Sales—Last 12 Months	Annual Sales— Current 12 Months
	$	$
	$	$
	$	$
	$	$
	$	$
	$	$
	$	$
	$	$

6. STAFF
   a. Indicate types of employees and number of each (if none, enter zero):

Type of Profession	Number	Type of Profession	Number
Pharmacists		Pharmacy Technicians	
RNs		Respiratory Therapists	
Physicians		Other (specify):	

   b. Are all of the above individuals licensed in accordance with applicable state and federal regulations? ☐ Yes ☐ No
   If no, attach an explanation.
   c. Do you supervise or contract with any individual other than your own employees? ☐ Yes ☐ No
   If yes, explain responsibilities and relationship to the entity which employs these individuals:

   d. Do you require all contracted staff (if any) to carry their own Professional Liability Insurance and secure Certificates of Insurance as evidence of such coverage? ☐ Yes ☐ No
   e. What limits of liability for Professional Liability are required? _____
7. RISK MANAGEMENT
   a. Are telephone orders taken only by a pharmacist from authorized professional staff and repeated back to the prescriber for verification? ☐ Yes ☐ No
   b. Do you accept electronic prescriptions? ☐ Yes ☐ No
   If yes, what safety controls are in place to assure prescriptions are prescribed by licensed physicians?

   c. Are products with known look-alike drug names stored separately and not alphabetically? ☐ Yes ☐ No
   d. What safety controls are in place to address problematic or look-alike drug names, packaging, or labeling?

   e. Are special alerts built into the system concerning problematic or look-alike drug names, packaging, or labeling? ☐ Yes ☐ No
   f. How do you detect drug contraindications, interactions, duplications against medical history and other prescribed drugs?

   g. Do you have access to drug information (i.e., Drug Facts and Comparisons, Micromedex, etc.)? ☐ Yes ☐ No
   h. Do you perform pediatric dose range checks? ☐ Yes ☐ No
   i. What criteria are established (i.e. targeted high-alert drugs, patient population) to trigger required medication counseling (i.e. alert tag on bag)?

   j. Are all prescriptions dispensed with current written instructions? ☐ Yes ☐ No
   k. How are drug wastes and expired drugs disposed of? _____
   l. Is the applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule? ☐ Yes ☐ No
   If yes,
      i. Has the applicant implemented procedures to comply with the HIPAA Privacy Rule? ☐ Yes ☐ No
      ii. Name and title of the applicant's privacy officer: _____

8. GENERAL LIABILITY

a. Please complete the following for each of your facilities if you desire general liability insurance:

Location Number	Location Name and Address	Description/Type of Facility	Square Footage	Parking Lot or Garage Maintained by Insured?	Adjacent Exposure?
1			SF	☐ Yes ☐ No	☐ Yes ☐ No
2			SF	☐ Yes ☐ No	☐ Yes ☐ No
3			SF	☐ Yes ☐ No	☐ Yes ☐ No
4			SF	☐ Yes ☐ No	☐ Yes ☐ No

b. Please complete the following for each location:

	Location 1	Location 2	Location 3	Location 4
Year built				
Year remodeled				
Number of stories				
Construction (frame, brick, or concrete)				
Percentage of building occupied by insured				
Other occupancy				

c. Is the building equipped with:

i. Complete sprinkler system? ☐ Yes ☐ No

ii. At least two clearly marked exits at each floor? ☐ Yes ☐ No

iii. Self-closing fire doors on each floor? ☐ Yes ☐ No

iv. Smoke detectors? ☐ Yes ☐ No

v. Automatic fire alarm system connected to local fire department? ☐ Yes ☐ No

vi. Emergency electrical system? ☐ Yes ☐ No

vii. Heat sensors? ☐ Yes ☐ No

viii. Fire escape(s)? ☐ Yes ☐ No

ix. Posted emergency evacuation procedures? ☐ Yes ☐ No

x. Properly maintained fire extinguishers? ☐ Yes ☐ No

d. Is a formal written safety program in place? ☐ Yes ☐ No

If yes, attach a copy of the safety program.

e. Are written procedures in effect for incident reporting? ☐ Yes ☐ No

f. Any exposure to flammables, explosive, chemicals? ☐ Yes ☐ No

g. Any catastrophe exposure? ☐ Yes ☐ No

If yes, explain: _____

h. Any exposure to radioactive materials? ☐ Yes ☐ No

i. Do operations involve storing, treating, discharging, applying, disposing of, or transporting hazardous materials? ☐ Yes ☐ No

j. Are there any elevators or escalators owned by you? ☐ Yes ☐ No

If yes, please indicate model and if the elevator and/or escalator is serviced by you under a maintenance contract:

9. APPLICANT HISTORY

a. Have you or any of your employees:

i. Ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital or professional association? ☐ Yes ☐ No

ii. Ever been convicted for an act committed in violation of any law ordinance other than traffic offenses? ☐ Yes ☐ No

If yes, attach disciplinary agency documents.

iii. Ever been treated for alcoholism or drug addiction? ☐ Yes ☐ No

iv. Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered? ☐ Yes ☐ No

If yes, attach disciplinary agency documents.

v. Ever had any insurance company or Lloyd's cancel, decline, refuse to renew or accept only on special terms their malpractice insurance?

10. EXISTING INSURANCE

Do you currently carry the following:

a. Professional Liability Insurance? ☐ Yes ☐ No

If yes, list the Professional Liability Insurance carried by the firm for each of the past **five** years including periods of no coverage:

Policy Period **FROM** MM/DD/YY	Policy Period **TO** MM/DD/YY	Insurance Company	Limit of Liability	Deductible	Policy Form: Claims Made **OR** Occurrence?	Premium
			$	$		$
			$	$		$
			$	$		$
			$	$		$
			$	$		$

If claims made, what is the retroactive date/prior acts date on your current policy? _____

b. Commercial General Liability Insurance? ☐ Yes ☐ No

If yes, list the Commercial General Liability Insurance currently carried by the firm:

Policy Period	Carrier	Limit of Liability BI/PD	Deductible	Policy Form: Claims Made **OR** Occurrence?	Premium
		$	$		$

If claims made, what is the retroactive date/prior acts date on your current policy? _____

11. CLAIMS HISTORY
    a. During the past five (5) years, have there been any professional or general liability claims or incidents made against you, any employee or former employee, the applicant or anyone proposed for this insurance? ☐ Yes ☐ No

       ATTACH CURRENTLY VALUED COMPANY LOSS RUNS FOR THE PRIOR FIVE (5) YEARS.

    b. Are you, or anyone proposed for this insurance aware of any fact(s), incident(s), act(s), event(s), circumstance(s) or occurrence(s) that may result in a claim(s) being made against you? ☐ Yes ☐ No
       If yes, provide full details:

    c. Have there been any prior complaints or incidents reported arising out of alleged or actual physical or sexual abuse or molestation?
       ☐ Yes ☐ No
       If yes, fully describe the circumstances and follow-up action taken:

APPLICANT SIGNATURE PANEL

THE APPLICANT DECLARES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE INCEPTION DATE OF THE POLICY PERIOD, WILL IMMEDIATELY NOTIFY THE UNDERWRITERS OF SUCH CHANGE. SIGNING OF THIS APPLICATION DOES NOT BIND THE UNDERWRITERS TO OFFER, NOR THE APPLICANT TO ACCEPT INSURANCE; BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE INSURANCE AND MADE A PART OF THE POLICY SHOULD A POLICY BE ISSUED.

APPLICABLE IN THE STATE OF NEW YORK: 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 ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONTAINING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

Notice applicable in most states: 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 any materially false information or conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent insurance act, which is a crime and may also be subject to civil penalty.

I/We hereby declare that the above statements and particulars are true and I/we agree that this application shall be the basis of the contract with the insurance company.

Authorized signature _____ Date _____

Typed or printed name: _____ Title: _____