

ADMIRAL INSURANCE COMPANY

6455 East Johns Crossing, Suite 240

Duluth, GA 30097

Phone: 770-476-1561 — Fax: 770-418-9597

Internet: <http://www.admiralins.com>

**PHARMACY
PROFESSIONAL LIABILITY
INSURANCE**

1. GENERAL INFORMATION

a. Full Name of Applicant: _____

b. Principal Address (List Additional Locations on a Separate Sheet):

c. Mailing Address: _____

d. Date Established: _____

2. OPERATIONS

a. Describe the nature of applicant's operations including types and percentage of services rendered:

Retail	_____	%
Wholesale	_____	%
Mail Order	_____	%
Drug Benefit	_____	%
Compounding	_____	%
Other	_____	%

Total 100%

b. Provide the following information for all of the States in which you are licensed:

State	License No.	Effective Date	Expiration Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

d. Complete the following information for each location you own.

Name & Address	Your Ownership %	Description of Operations
_____	_____	_____
_____	_____	_____
_____	_____	_____

- e. Do you have any International Operations? Yes _____ No _____
- f. Are any drugs imported? Yes _____ No _____ If yes, please attach an explanation.
- g. Does a license physician in State where services are rendered issue all prescriptions? Yes _____ No _____
- h. Is pharmacy in compliance with all local, state and federal laws that govern the manufacture, control, dispensing and distribution of prescription drugs? Yes _____ No _____
- i. Annual Number of prescriptions filled _____
- j. 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 _____	\$ _____	\$ _____
TOTAL	\$ _____	\$ _____

- k. Is the applicant a “Covered Entity” under the Health Insurance Portability and Accountability Act of 1996 (HIPPA) Privacy rule? Yes _____ No _____
- l. If yes,
 (i) Has the Applicant implemented procedures to comply with the HIPPA Privacy Rule? Yes ___ No ___
 (ii) Provide the name and title of the Applicant’s Privacy Officer: _____

3. PROFESSIONAL SERVICES

- a. Do you provide mail order services? Yes _____ No _____
 If Yes, provide details of safety controls to assure a licensed physician authorizes prescriptions.
- b. Do you provide services to the following:
 Nursing Home _____ Hospitals _____ Extended Care Facility _____ Correctional Facilities _____
 MCO’s _____ If yes, please provide a copy of the 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, please attach list of five (5) largest clients and provide 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 equipment** you sell or lease or repair for others:

Type	Annual Sales	Last 12 Months	Current 12 Months

- (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? Yes ___ No ___

b. Please list Professional Liability Insurance carried for each of the past five years. If none, state none.

Insurance Carrier	Policy Number	Limits of Liability	Deductible	Premium	Inception Mo./Day/Yr.	Claims Made?		Retro Date
						Yes	No	
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____

c. Has any claim or suit been brought against you and/or any of your employees? Yes _____ No _____
If yes, please provide the following information:

1. If a current loss summary is available from the present and previous carrier, please attach a copy.
2. If a loss summary is not available, attach a Supplemental Claim information Form showing the following information for each claim:
 - (i) Date of event and date claim was reported to the insurance company
 - (ii) Description (cause) or loss or claim
 - (iii) Location of loss
 - (iv) Current status (open or closed)
 - (v) Paid amount and current reserve amount
3. Are you aware of any circumstances which may result in a malpractice claim or suite being made or brought against you or any of your employees? Yes _____ No _____
If yes, attach details.

d. Please list prior General Liability Insurance carried for each of the past five years. If none, state none.

Insurance Carrier	Policy Number	Limits of Liability	Deductible	Premium	Inception Mo./Day/Yr.	Claims Made?		Retro Date
						Yes	No	
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____

7. **GENERAL LIABILITY**

a. Please complete the following for each of your locations if you desire General Liability Insurance:

Location Number	Parking Lot or Name and Location Address	Description of Type of Facility	Garage Maintained by Insured?		Adjacent Exposure		Square Footage
			Yes ___ No ___	Yes ___ No ___	Yes ___ No ___	Yes ___ No ___	
_____	_____	_____	Yes ___ No ___	Yes ___ No ___	Yes ___ No ___	Yes ___ No ___	_____
_____	_____	_____	Yes ___ No ___	Yes ___ No ___	Yes ___ No ___	Yes ___ No ___	_____
_____	_____	_____	Yes ___ No ___	Yes ___ No ___	Yes ___ No ___	Yes ___ No ___	_____

b. Please complete the following for each location:

- (i) Year Built _____
- (ii) Year Remodeled _____
- (iii) Number of Stories _____
- (iv) Construction: Frame, Brick Concrete _____

- (v) Percentage of Building Occupied by Insured _____
- (vi) Other Occupancy _____
- (vii) Location Number _____

- 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) Automatic fire alarm system connected to local fire department? Yes___ No___
 - (v) Smoke detectors? 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, please attach a copy of the safety program)
- e. Are written procedures in effect for incident reporting? Yes___ No___
- f. Any exposure to flammables, explosives, chemicals? Yes___ No___
- g. Any catastrophe exposure? Yes___ No___
- h. Any exposure to radioactive materials? Yes___ No___
- i. Do operations involve storing, treating, discharging, applying, disposing, or transporting hazardous materials? Yes___ No___
- j. Machinery or equipment loaned or rented to others? Yes___ No___
- k. Are there any elevators or escalators owned by you? Yes___ No___
If yes, please indicate model and if the elevator and/or escalator is services by you under a maintenance contract.
- l. Any parking facilities provided? Yes___ No___
- m. Recreation facilities provided? Yes___ No___
- n. Is there a swimming pool on the premises? Yes___ No___
- o. Sporting or social events sponsored? Yes___ No___

10 year General Liability Loss History (attach further sheets if needed)

p.	Date of Occurrence	Date Claim Made	Description of Loss	Amount of Loss Reserved	Amount of Loss Expenses Paid	Open (O)	
						Expenses Reserved	or Closed (C)

- q. Are you aware of any circumstances that may result in a general liability claim or suit being made or brought against you? Yes___ No___
If yes, please attach a Supplemental Claim Form

NOTICE TO APPLICANT: The coverage applied for is SOLELY AS STATED IN THE POLICY, which provides coverage on a "CLAIMS MADE" basis for ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD unless the extended reporting period option is exercised in accordance with the terms of the policy.

WARRANTY: I/We warrant to the insurer, that I understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy of insurance and deemed incorporated herein, should the Insurer evidence its acceptance of this application by issuance of a policy. I/We authorize the release of claim information from any prior Insurer to Admiral Insurance Company.

Name of Applicant

Title (Officer, partner, etc.)

Signature of Applicant

Date

SIGNING this application does not bind the Applicant or the Insurer to complete the insurance, but one copy of this application will be attached to the policy, if issued.