



PHARMACY PROFESSIONAL LIABILITY APPLICATION and GENERAL LIABILITY APPLICATION (CLAIMS MADE AND REPORTED COVERAGE)

SECTION I – GENERAL INFORMATION

- 1) Full Name of Applicant:

- 2) Principal Address (List additional locations on a separate sheet):

- 3) Mailing Address:

- 4) Date Established:

- 5) FEIN:

SECTION II – OPERATIONS

- 6) Describe the nature of the applicant’s operations including types and percentage of services rendered:

Retail	%
Wholesale	%
Mail Order	%
Drug Benefit	%
Compounding	%
Sundries	%
Other	%
Total	100%

- 7) Provide the following information for all the States in which you are licensed:

State	License Number	Effective Date	Expiration Date

- 8) Are all drugs dispensed FDA approved? Yes No
If No, attach an explanation.

9) Complete the following information for each location you own.

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

- 10) Do you have any international operations? Yes No
- 11) Are any drugs imported? Yes No
If Yes, attach an explanation.
- 12) Is this pharmacy part of a franchise or chain? Yes No
- 13) Are IDs checked to verify the age of patrons prior to the sale of alcohol and tobacco? Yes No
- 14) Does a licensed physician, in State where services are rendered, issue all prescriptions? Yes No
- 15) Is pharmacy in compliance with all local, state and federal laws that govern the manufacture, control, dispensing and distribution of prescription drugs? Yes No
- 16) Annual number of prescriptions filled:
- 17) What is the percentage of prescriptions filled that are derived from opioids? %
- 18) Do you or will you source opioids directly from any manufacturer? Yes No
- 19) Do you adhere to any and all prescription drug monitoring program (PDMP) requirements in the state(s) in which you do business? Yes No
- 20) Do you fully comply with the [CDC Guideline for Prescribing Opioids](#)? Yes No

21) 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	\$	\$

- 22) Is the applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule? Yes No
If Yes:
- a. Has the applicant implemented procedures to comply with HIPAA Privacy Rule? Yes No
- b. Provide the name and title of the applicant's Privacy Officer:

SECTION III – PROFESSIONAL SERVICES

23) Do you provide services of the following:

- | | | |
|-------------------------|------------------------|------------------------|
| Nursing Home | Hospitals | Extended Care Facility |
| Correctional Facilities | Managed Care Operation | Other: |

- 24) 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
- 25) Do you compound in bulk, manufacture, or wholesale drugs or products? Yes No
- 26) 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
	\$	\$	\$
	\$	\$	\$
	\$	\$	\$
	\$	\$	\$

SECTION IV – STAFF

- 27) List the number of each type of profession on staff:

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

- 28) Are all of the above individuals licensed in accordance with applicable state and federal regulations?
If No, attach an explanation. Yes No
- 29) Do you supervise or contract with any individual other than your own employees?
If Yes, provide an explanation of the responsibilities and relationship to the entity, which employs these individuals: Yes No
- 30) Do you require all contracted staff (if any) to carry their own Professional Liability Insurance?
Do you secure Certificates of Insurance as evidence of such coverage? Yes No
Yes No
- 31) What limits of Professional Liability required?

SECTION V – NETWORK SECURITY AND DATA PRIVACY PROCEDURES

- 32) Do you currently purchase a standalone cyber policy?
If Yes, provide the following information: Yes No

Carrier	Limit	Deductible	Premium	Policy Term	Retro Date

- 33) Do you employ the following tools to protect private sensitive data?
- a. Anti-Virus and Firewalls Yes No
 - b. Encryption Yes No
 - c. Formal Password Management Procedures Yes No
- 34) Are you compliant with the Health Information Portability and Accountability Act (HIPAA) and Health Information Technology for Economic Critical Health Act (HITECH)? Yes No

35) Have you ever experienced a security breach, data loss or denial of service attack?
If Yes, complete a [Supplemental Claim Information Form](#) for each and every claim. Yes No

SECTION VI – RISK MANAGEMENT

36) Are telephone orders only taken by a pharmacist from authorized professional staff and repeated back to the prescriber for verification? Yes No

37) Are products with known look-alike drug names stored separately and not alphabetically? Yes No

38) Do you have access to drug information? (i.e. Drug Facts and Comparisons, Micromedex, etc.) Yes No

39) Do you perform pediatric dose range checks? Yes No

40) How do you detect drug contradictions, interactions, duplications against medical history and other prescribed drugs?

41) What safety controls are in place to address problematic or look-alike drug names, packaging or labeling?

42) Are special alerts built into the system concerning problematic or look-alike drug names, packaging or labeling? Yes No

43) What criteria are established (i.e. targeted high-alert drugs, patient population) to trigger required medication counseling (i.e. alter tag on bag)?

44) Are all prescriptions dispensed with current written instructions? Yes No

45) Do you accept electronic prescriptions?
If Yes, what safety controls are in place to assure prescriptions are prescribed by licensed physicians? Yes No

46) How are drug wastes and expired drugs disposed of?

SECTION VII – CLAIMS HISTORY

47) Have you or any of your employees:

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

b. Ever been convicted for an act committed in violation of any law ordinance other than traffic offenses?
If Yes, attach disciplinary agency documents. Yes No

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

- d. 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 suspended? Yes No
If Yes, attach disciplinary agency documents.
- e. Ever had any insurance company or Lloyd's cancel, decline, refuse to renew or accept only on special terms their malpractice insurance? Yes No

48) Please list Professional Liability insurance carried for each of the past five years. If none check here:

Carrier	Policy Number	Limits of Liability	Deductible	Premium	Inception (mm/dd/yy)	Claims Made?	Retro Date
						Yes No	
						Yes No	
						Yes No	
						Yes No	
						Yes No	

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

- a. If a current loss summary is available from the present and previous carrier, please attach a copy.
- b. If a loss summary is not available, attach a [Supplemental Claim Information Form](#) for each and every claim.
- c. Are you aware of any circumstances which may result in a malpractice claim or suit being made or brought against you or any of your employees? Yes No

50) Do you currently carry GL and Products Liability? Yes No

51) Are you interested in a quote for General Liability? Yes No
If Yes, complete the General Liability Supplemental Application below.

GENERAL LIABILITY SUPPLEMENTAL APPLICATION

SECTION I – YOUR LOCATIONS

IF YOU HAVE MORE THAN FIVE (5) LOCATIONS, PROVIDE A SPREADSHEET WITH THE INFORMATION BELOW FOR EACH LOCATION.

1)

Loc #	Facility Name	Address	Description / Use	Square Footage
1				
2				
3				
4				
5				

	Location 1	Location 2	Location 3	Location 4	Location 5
Own or Lease	Own Lease	Own Lease	Own Lease	Own Lease	Own Lease
% occupied by applicant	%	%	%	%	%
Are there other occupants?	Yes No	Yes No	Yes No	Yes No	Yes No
# of beds / units (if applicable)					

SECTION II – MAINTENANCE

- 2) Does the Applicant have a full-time maintenance staff? Yes No

Confirm the type of maintenance, service and repair performed by the Applicant (Direct) or subcontracted (Subbed) by completing the table below.

NOTE: Direct is a percentage of total direct payroll and Subbed is a percentage of total subcontractor cost.

Type	Direct	Subbed
Snow & Ice Removal	%	%
Janitorial/Cleaning Services	%	%
General Maintenance & Repairs	%	%
Landscaping	%	%
Other:	%	%

- 3) Does the Applicant have written procedures for routine inspections of the premises to identify and address potential liability hazards? Yes No

If Yes, are records of the completed inspections and repairs retained for at least five years? Yes No

- 4) Are there any construction projects planned for the upcoming policy term? Yes No

If Yes, provide full details of project, location, total costs, payroll and sub costs:

a. Will the construction be subbed out? Yes No

b. Are signs clearly posted to warn the third party of construction and/or during routine Maintenance? Yes No

SECTION III – FIRE-LIFE SAFETY INFORMATION

- 5) Are all of your locations equipped with:

a. Complete sprinkler system? Yes No

b. At least two clearly marked exits on each floor? Yes No

c. Smoke detectors? Yes No

d. Emergency electrical system? Yes No

e. Heat sensors? Yes No

f. Fire escape(s)? Yes No

g. Posted emergency evacuation procedures? Yes No

h. Properly maintained fire extinguishers? Yes No

i. Self-Closing Fire doors on each floor? Yes No

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

Attach a separate sheet detailing any No answers.

6) Any Exposure to flammables, explosives or chemicals? Yes No

7) Any exposure to radioactive materials? Yes No

8) Do operations involve storing, treating, discharging, applying, disposing or transporting hazardous materials? Yes No

SECTION IV – OTHER PREMISES EXPOSURES

9) Does the applicant secure written contracts with all subcontractors, security guard service, and/or tenants? Yes No

If Yes, does the contract require them to:

a. Carry \$1,000,000 Occurrence / \$2,000,000 General Aggregate Limits in General Liability coverage or greater? Yes No

b. Name the Applicant as an Additional Insured? Yes No

c. Defend, indemnify, and hold the Applicant harmless? Yes No

d. Maintain Workers Compensation insurance (if not a tenant)? Yes No

10) Are surveillance cameras on the premises? Yes No

11) Is the door to the pharmacy department securely locked during the store's hours of operations? Yes No

12) Are there any elevators or escalators owned by you? Yes No

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

13) Are any parking facilities provided? Yes No

14) Are any of the following provided:

a. Sale of any food or drinks? Yes No

b. Recreational facilities? Yes No

c. Gym or exercise equipment available to members or the public? Yes No

d. Swimming pool on any premises? Yes No

e. Daycare or childcare services? Yes No

f. Sponsor any sporting or social events? Yes No

g. Hold any fundraising events? Yes No

h. Provide alcohol with any of your events or services? Yes No

i. Participation in trade shows, exhibits or conventions? Yes No

j. Any plans for new construction or renovations during the next twelve (12) months? Yes No

Attach a separate sheet detailing any Yes answers.

15) Are written procedures in effect for incident reporting? Yes No

16) Is a formal written safety program in place? Yes No

If Yes, attach a copy of the safety program.

SECTION V – PRODUCTS AND EQUIPMENT SOLD OR LEASED

- 17) Do you loan, lease or rent equipment to others? Yes No
- a. Annual gross revenue for equipment rental? \$
- b. With or without operator (technician)? With Without
Provide details:
- c. Who is responsible for equipment maintenance?

- 18) Do you sell durable medical equipment? Yes No
If Yes, complete the following table for Medical Equipment Suppliers Revenue:

	Annual Sales	Annual Lease/Rental
Category I: Expendable Items (i.e. adhesive tape, bandages, hypodermic needles)	\$	\$
Category II: Non-Expendable Items (i.e. hospital beds, bathroom safety bars, canes, walkers, wheelchairs, crutches, IV stands, etc.)	\$	\$
Category III: Diagnostic or Treatment Devices (i.e. oxygen, IV pumps, blood pressure gauges, transmitting devices)	\$	\$
Category IV: Life Sustaining or Critical Life Monitoring Equipment or Devices (i.e. dialysis machines, heart/lung machines, ventilators, etc.)	\$	\$

- 19) Is machinery or equipment loaned or rented to others? Yes No

SECTION VI – ADVERTISING

- 20) Do you obtain proper consents and utilize contractual agreements prior to using the image/oral/written publication of any person/celebrity? N/A Yes No
- 21) Are you making any structure/function claims for your products on labels, websites or other marketing materials? Yes No
- Do you maintain documentation that substantiates each claim you make? Yes No
If Yes, explain the documentation and length of time records are retained:

SECTION VII – ADDITIONAL INSUREDS

- 22) List all parties that should be considered for Additional Insured status under the General Liability. Include a copy of the contract for each entity and a certificate of insurance evidencing GL coverage in place.

Name and Address	Relationship to Applicant

SECTION VIII – PRODUCTS & COMPLETED OPERATIONS

Attach a separate sheet detailing any Yes answers, along with a list of products sold.

If product labels cannot be found on your website, include copies with this application.

23) Do you sell any products? Yes No
If No, skip to question 29.

If Yes, answer the following questions and include product brochures.

Describe the types of products you sell:

24) Total gross revenue **from product sales:**

a. Last twelve (12) months: \$

b. Next twelve (12) months: \$

25) Any herbal supplements, homeopathic remedies, and/or nutraceuticals? Yes No

26) Do any of your products include:

a. Caffeine exceeding 300 mg per servicing (all sources)? Yes No

b. Cannabidiol (CBD) hemp products? Yes No

c. Class I & Class II Medical Products / Devices? Yes No

27) Do you mix or compound any ingredients? Yes No

28) Is a prescription required for any of the products you sell? Yes No

29) Are products of others sold or re-packaged under your label? Yes No

30) Do all of your labels include a disclaimer that the FDA has not evaluated the claims on your labels and that your products are not intended to diagnose, treat, cure or prevent any diseases? Yes No

31) Do you obtain Certificates of Insurance from all suppliers evidencing Product Liability Insurance? Yes No

32) Are foreign products sold, distributed, or used as components? Yes No

33) Have any of your products been recalled, discontinued or changed? Yes No

34) Do you offer training or instruction to the user of your products? Yes No

35) Do you offer guarantees, warranties or Hold Harmless agreements with your products? Yes No

36) Do you install, service or demonstrate products? Yes No

37) Is research and development conducted on new products? Yes No

38) Are any new products planned in the next year? Yes No
If Yes, provide explanation:

39) Are you a manufacturer, wholesaler or importer of products to others? Yes No

If Yes, answer the following questions and attach a separate sheet detailing any No answers, along with copies of product labels (if not available on website).

a. Are all warning labels and instructions for use reviewed by outside legal counsel? Yes No

b. Has legal counsel reviewed your labeling and confirmed it is in compliance with regulations established by the FDA and FTC? Yes No

- c. Have you conducted or are you planning to conduct human clinical trials to substantiate your product claims? Yes No

SECTION IX – PRIOR GENERAL LIABILITY COVERAGE HISTORY

40) List prior General Liability insurance carried for each of the past five (5) years. If NONE, check this box

Insurance Company	Limits of Liability	Deductible	Premium	Expiration Mo/Day/Yr	Was this a Claims Made Policy Form?		Retro Date
					Yes	No	
					Yes	No	
					Yes	No	
					Yes	No	
					Yes	No	
					Yes	No	

SECTION X – CLAIMS

PROVIDE 5 YEARS OF CURRENTLY VALUED LOSS RUNS.

- 41) Has any General Liability claim or suit been brought against you and/or any of your employees? Yes No
 If Yes, complete a [Supplemental Claim Information Form](#) for each and every claim or suit.

- 42) Are any persons or entities proposed for this insurance aware of any fact, circumstance, or situation which may result in a GL claim, and has not been reported to your current GL insurance carrier? None to Report Yes No
 If Yes, provide details:

- 43) Are you aware of any incident, condition, circumstance, defect or suspected defect in any product, which may result in a claim or claims against you that are not listed above? None to Report Yes No
 If Yes, provide details:

Fraud Notices

Applicable in AL, AR, DC, LA, MD, NM, RI and WV: Any person who knowingly (or willfully)* presents a false or fraudulent claim for payment of a loss or benefit or knowingly (or willfully)* presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. *Applies in MD only.

Applicable in CO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Applicable in FL and OK: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony (of the third degree)*. * Applies in FL only.

Applicable in KS: Any person who knowingly and with intent to defraud, presents, causes to be presented, or prepares with knowledge or belief that it will be presented, to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

Applicable in KY, NY, OH and PA: 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 fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties (not to exceed five thousand dollars and the stated value of the claim for each such violation)*. *Applies in NY only.

Applicable in ME, TN, VA, and WA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties (may)* include imprisonment, fines and denial of insurance benefits. *Applies in ME only.

Applicable in NJ: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Applicable in OR: Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.

Applicable in PR: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars (\$5,000) and not more than ten thousand dollars (\$10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Applicable in all other 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.

Other State Notices

Applicable in RI: THIS INSURANCE CONTRACT HAS BEEN PLACED WITH AN INSURER NOT LICENSED TO DO BUSINESS IN THE STATE OF RHODE ISLAND BUT APPROVED AS A SURPLUS LINES INSURER. THE INSURER IS NOT A MEMBER OF THE RHODE ISLAND INSURERS INSOLVENCY FUND. SHOULD THE INSURER BECOME INSOLVENT, THE PROTECTION AND BENEFITS OF THE RHODE ISLAND INSURERS INSOLVENCY FUND ARE NOT AVAILABLE.

I/We understand that this is an application for insurance only and that the completion and submission of this Application does not bind the Company to sell nor the applicant to purchase this insurance. I/We hereby declare that the above statements and particulars are true and I/we agree that this Application shall be the basis for any contract of insurance issued by the Company in response to it.

Electronic Signature of Applicant or Authorized Representative:

Title:

Date:

If you prefer not to return the questionnaire with an electronic signature, please print and sign.