Professional & General Liability Application for Pharmacies

1. Name of Applicant: _____
(as it should appear on the policy)

2. Mailing Address: _____

3. Location Address: _____
(If more than one location address, please attach list including gross receipts by location)

4. Telephone Number: _____ Website Address: _____

5. Exposure:

Gross Receipts for the Past 12 Months:	$
Estimated Gross Receipts for the Next 12 Months:	$
Payroll for the Past 12 Months:	$
Estimated Payroll for the Next 12 Months:	$
Number of Prescriptions Filled over the Past 12 Months:	
Estimated Number of Prescriptions Filled for Next 12 Months:	

6. Description of Services Provided: _____

_____

7. Does the applicant own or manage any other businesses or locations not shown on this application?

Yes ☐ No ☐

If yes, is there separate professional and general liability coverage for these other operations elsewhere at a minimum of $1M/$3M limits and does the applicant agree to maintain separate coverage in force for these other operations throughout the duration of this policy?

Yes ☐ No ☐

8. Is the applicant a member of any association or certified or accredited by any governing body? If yes, give details:

_____

_____

9. Exposure: Please complete the table below showing the % exposure in each of the areas listed in terms.

NOTE: If this is a start-up business not yet in operation, please show estimated % exposures for the next 12 months in each of the areas listed.

	% Exposure
Compounding Medications	
Dispensing of Opioids	
Drug Benefit Services	
Mail Order	
Retail	
Wholesale	
Specialized Pharmacy Services (e.g. Veterinarian services)	
Grow, Blend or Prepare Medical Marijuana and/or Herbal Remedies	
Other (please describe):	

10. Are any of the exposures listed in the above table expected to change over the next 12 months?

Yes ☐ No ☐

If yes, please provide details: _____

_____

11. Do you sell, rent or otherwise provide any equipment to products or others? Yes ☐ No ☐

If yes, please complete the supplement for Durable Medical Equipment Sales/Rentals.

12. Do you dispense any drugs that are:

a) Imported from outside of the United States of America? Yes ☐ No ☐

If yes, provide details: _____

b) Not FDA approved? Yes ☐ No ☐

If yes, provide details: _____

13. Are all prescriptions authorized by a licensed physician licensed in the state where services are provided?

Yes ☐ No ☐ If no, provide details: _____

14. Are you in compliance with all local, state and federal laws that govern the manufacture, control, dispensing and distribution of prescription drugs?

Yes ☐ No ☐ If no, provide details: _____

15. Are telephone orders only taken by a pharmacist and repeated back for verification?

Yes ☐ No ☐

16. Are products with known look-alike drug names stored separately and not alphabetically?

Yes ☐ No ☐

17. Does the applicant perform pediatric dose range checks? Yes ☐ No ☐

18. Are all prescriptions dispensed with current written instructions? Yes ☐ No ☐

19. Does the applicant accept electronic prescriptions? Yes ☐ No ☐

If yes, what controls are in place to ensure prescriptions are prescribed by a licensed physician?

_____

20. How are drug waste and expired drugs disposed of? _____

21. a) List the number and type of employees/owners including any estimated over the next 12 months:

	Number		**Number**
Pharmacist		Pharmacy Technician	
Physician (patient contact)		Physician (no patient contact)	
Physician Assistant		Nurse Practitioner	
Nurse		Paramedic/EMT	
Physical/Occupational/Speech Therapist		Non-Medical Aide/Caregiver	
Chiropractor		Acupuncturist	
Admin/Clerical		Other (please describe)	

b) List the number and type of independent contractors including any estimated over the next 12 months:

	Number		**Number**
Pharmacist		Pharmacy Technician	
Physician (patient contact)		Physician (no patient contact)	
Physician Assistant		Nurse Practitioner	
Nurse		Paramedic/EMT	
Physical/Occupational/Speech Therapist		Non-Medical Aide/Caregiver	
Chiropractor		Acupuncturist	
Admin/Clerical		Other (please describe)	

c) Are all the individuals listed in response to Q17a & b licensed in accordance with applicable state and federal regulations?

Yes ☐ No ☐ If no, attach explanation.

22. Do you require contracted staff (if any) to carry their own Professional Liability Insurance & secure certificates of Insurance as evidence of such coverage?

Yes ☐ No ☐ If yes, at what limits? $_____ / $_____

If no, is coverage desired with shared limits on this policy? Yes ☐ No ☐

23. Please confirm which of the following you obtain, review, verify and keep on file as part of the employee/ independent contractor hiring & screening process:

	Yes	**No**
Employment Application		
Criminal Background Checks		
Drug / HIV/ Hepatitis Testing		
Licenses Held		
Education/Training/Competence		
Multi-State Registry		

24. Additional employment related questions:

	Yes	No
Do you question prospective employees/independent contractors about prior claims or suits?		
Are employees required to actively participate in continuing education?		
Do you prepare job descriptions and instructional manuals for your staff?		
Do you have a written incident/occurrence reporting policy and procedures?		
Are all owners/employees/independent contractors current on any training that is required by the state or any other governing body, and is there proof of any required training on file at the home/facility for review?		

25. Please complete the table below showing the applicant's Professional Liability coverage for last 5 years:
(if none, state none)

Carrier	Limit	Deductible	Premium	Expiration Date	Retro Date (if applicable)

26. Please complete the table below showing the applicant's General Liability coverage for last 5 years:
(if none, state none)

Carrier	Limit	Deductible	Premium	Expiration Date	Retro Date (if applicable)

27. Has the applicant or have any of their employees (please attach a detailed explanation for any "yes" answers):

	Yes	No
a) Ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital or professional association?		
b) Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses?		
c) 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 same?		
d) Ever had an application for Professional Liability Insurance made on their behalf which has been declined or has their insurance ever been cancelled or renewal refused?		

28. Has any claim ever been made against the firm or any of its employees?

Yes ☐ No ☐ **If yes, please attach completed claims supplement.**

29. Is the applicant aware of any circumstances which may result in any claim against him, the firm, his predecessors in business, or any of the present or past Partners or Officers?

Yes ☐ No ☐ **If yes, please attached a separate sheet with date(s) and details.**

Application for Claims-Made Professional Liability Insurance

The undersigned declares that to the best of his/her knowledge the statements herein are true. Signing of this Application does not bind the undersigned to complete the insurance, but it is agreed that this Application shall be the basis of the contract should a Policy be issued, and that this Application will be attached and become part of such Policy, if issued. Underwriters hereby are authorized to make any investigation and inquiry in connection with this Application, as they deem necessary.

Name of Applicant: _____
Please Print Title

Signature: _____
Name Date

(NOTE: Application must be signed by the owner or president or principal)