

**APPLICATION  
FOR PHARMACIES/PHARMACISTS  
PROFESSIONAL LIABILITY AND GENERAL LIABILITY INSURANCE  
(CLAIMS MADE AND REPORTED BASIS)**

Please email this application back to the underwriter you are working with.  
For contact information please visit [www.usrisk.com/healthcare.html](http://www.usrisk.com/healthcare.html)

Effective date desired: \_\_\_\_\_

1. Complete name of applicant (if other than parent firm, supply full details of ownership entity) **(use an additional sheet of paper if necessary)**: \_\_\_\_\_  
 \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_  
 Contact name: \_\_\_\_\_ Title: \_\_\_\_\_ Email address: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Web site Address: \_\_\_\_\_ Fax: \_\_\_\_\_  
 List all other locations **(use an additional sheet of paper if necessary)**: \_\_\_\_\_  
 \_\_\_\_\_

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:

	%	
Retail	_____	_____
Wholesale	_____	_____
Mail Order	_____	_____
Drug Benefit	_____	_____
Compounding	_____	_____
Other (Specify)	_____	_____

Must Total 100%

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

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

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

c. Are any drugs imported?  Yes  No  
 If yes, please attach explanation. \_\_\_\_\_

d. Does licensed physician in State where services are rendered issue all prescriptions?  Yes  No

e. 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, provide details of safety controls to assure a licensed physician authorizes prescriptions.

b. Do you provide services to the following:  
 Nursing Homes  Hospitals  Extended Care Facilities  Correctional Facilities  MCOs  
 If yes, please provide 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, 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/or equipment** you sell or lease or repair for others:

**ANNUAL SALES**

TYPE OF SUPPLIES AND/OR EQUIPMENT	LAST 12 MONTHS	CURRENT 12 MONTHS

**6. STAFF:**

a. <u>Number</u> Type of Profession _____ Pharmacists _____ RNs _____ Physicians	<u>Number</u> Type of Profession _____ Pharmacy Technicians _____ Respiratory Therapists _____ Other (specify) _____
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b. Are all of the above individuals licensed in accordance with applicable state and federal regulations?  Yes  No  
 If no, please attach an explanation. \_\_\_\_\_

c. Do you supervise or contract with any individual other than your own employees?  Yes  No  
 If yes, please provide explanation of responsibilities and relationship to the entity which employs these individuals.

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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 only taken 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?

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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,

a. Has the Applicant implemented procedures to comply with the HIPAA Privacy Rule?  Yes  No

b. Provide the 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:

<u>Location Number</u>	<u>Name and Location Address</u>	<u>Description of Type of Facility</u>	<u>Square Footage</u>	<u>Parking Lot or Garage Maintained by Insured?</u>	<u>Adjacent Exposure?</u>
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

b. Please complete the following for each location:

(i)	Location Number	_____	_____	_____
(ii)	Year built	_____	_____	_____
(iii)	Year Remodeled	_____	_____	_____
(iv)	Number of Stories	_____	_____	_____
(v)	Construction: Frame, Brick, Concrete	_____	_____	_____
(vi)	Percentage of Building Occupied by Insured	_____	_____	_____
(vii)	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?  
(if yes, please attach a copy of the safety program.)  Yes  No
- e. Are written procedures in effect for incident reporting?  Yes  No
- f. Any exposure to flammables, explosive, chemicals?  Yes  No
- g. Any catastrophe exposure?(Explain)  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. 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?  Yes  No

**10. INSURANCE INFORMATION:**

- a. **Do you currently carry the following:** Professional Liability Insurance?  Yes  No  
List the Professional Liability Insurance carried by the firm for each of the past **five** years including periods of no coverage.

Policy Period		Insurance Company	Limit of Liability	Deductible	Policy Form: Claims Made or Occurrence?	Premium
From: MM/DD/YY	To: MM/DD/YY					
/ /	/ /					
/ /	/ /					
/ /	/ /					
/ /	/ /					
/ /	/ /					

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

