

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

**Please email this completed application to the U.S. Risk underwriter you are working with.**

For contact information, please visit the [U.S. Risk HealthcarePros webpage](#).

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): _____	\$ _____	\$ _____
<b>TOTAL</b>	<b>\$ _____</b>	<b>\$ _____</b>

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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2	_____	_____	_____ SF	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3	_____	_____	_____ SF	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4	_____	_____	_____ SF	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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 <b>OR</b> 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 <b>OR</b> 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:

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**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: \_\_\_\_\_