APPLICATION FOR PHARMACY PROFESSIONAL LIABILITY INSURANCE

(Claims Made Basis)

APPLICANT'S INSTRUCTIONS:

1. Answer all questions. If the answer requires detail, please attach a separate sheet.
2. Application must be signed and dated by owner, partner or officer.
3. Please do not complete application earlier than 45 days before proposed effective date of coverage.
4. PLEASE READ CAREFULLY THE STATEMENTS AT THE END OF THIS APPLICATION.

(PLEASE TYPE OR PRINT IN INK)

1. GENERAL INFORMATION

a. Full name of Applicant: _____

b. Principal Business Address: _____

c. Business Phone: (___)_____ E-Mail Address: _____Website: _____

d. Date established: _____

Please attach proforma business plan if this is a start-up.

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 explanation.

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

Name and 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 explanation.

g. Does licensed 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 (HIPAA) Privacy Rule?……Yes ___No___

l. If yes,

(i) Has the Applicant implemented procedures to comply with the HIPAA Privacy Rule? Yes ___ No ____

(ii) Provide the name and title of the Applicant's Privacy Officer: _____

Our Business Associate Agreement is available at www.markelshand.com. This is the only Business Associate Agreement we will recognize.

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 _____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. Do you provide specialized pharmacy services such as nuclear, veterinarian or other ? Yes ____ No ____
If yes, please provide details.

f. Are you a member of the Institute for safe Medication Practices (ISMP)? Yes ____ No ____

g. Please indicate the type of **medical supplies and/or equipment** you sell or lease or repair for others:

TYPE	ANNUAL SALES	LAST 12 MONTHS	CURRENT 12 MONTHS

4. STAFF

a.

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

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. _____

_____

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 of Professional Liability are required? _____

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

c. Do you have access to drug information (i.e., Drug Facts and Comparisons, Micromedex etc.)? Yes__ No__

d. Do you perform pediatric dose range checks? Yes_____ No ____

e. How do you detect drug contraindications, interactions, duplications against medical history and other prescribed drugs?

f. What safety controls are in place to address problematic or look-alike drug names, packaging, or labeling? _____

g. Are special alerts built into the system concerning problematic or look-alike drug names, packaging, or labeling? Yes ____ No_____

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

i. Are all prescriptions dispensed with current written instructions? Yes___ No____

j. Do you accept electronic prescriptions? Yes___ No___ if yes, what safety controls are in place to assure prescriptions are prescribed by licensed physicians?

k. How are drug wastes and expired drugs disposed? _____

6. APPLICANT HISTORY/CLAIMS

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 ____

b. Please list Professional Liability insurance carried for each of the past ten years. IF NONE, STATE NONE.

Insurance Carrier	Policy Number	Limits of Liability	Deductible (if any)	Premium	Inception Mo./Day/Yr.	Expiration Mo./Day/Yr.	Was this a Claims Made Policy Form? Yes	No	Retro Date
							[ ]	[ ]	
							[ ]	[ ]	
							[ ]	[ ]	

c. Has any claim or suit been brought against you and/or any of your employees? Yes ___ No ___ if yes, 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) of 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 suit 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 (if any)	Premium	Inception Mo./Day/Yr.	Expiration Mo./Day/Yr.	Was this a Claims Made Policy Form? Yes	No	Retro Date
							[ ]	[ ]	
							[ ]	[ ]	
							[ ]	[ ]	

7. GENERAL LIABILITY

a. Please complete the following for each of your facilities 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
(i)	_____	_____	_____	[ ] Yes [ ] No	[ ] Yes [ ] No	_____
(ii)	_____	_____	_____	[ ] 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, explosive, 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 serviced by you under a maintenance contract. .....

l. Any parking facilities owned/rented? ..... [ ] 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	Amount Description of Loss	Amount of of Loss Reserved	Amount Expenses Paid	Amount of of Loss Reserved	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 therein, 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 the underwriting manager, Company and/or affiliates thereof.

Name of Applicant	Title (Officer, partner, etc.)
Signature of Applicant	Date

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