Admiral INSURANCE GROUP | a Berkley Company

PHARMACY PROFESSIONAL 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 (HIPPA) Privacy Rule? Yes No
If Yes:

a. Has the applicant implemented procedures to comply with HIPPA 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? ◯ Yes ◯ No
If No, attach an explanation.

29) Do you supervise or contract with any individual other than your own employees? ◯ Yes ◯ No
If Yes, provide an explanation of the responsibilities and relationship to the entity, which employs these individuals:

30) Do you require all contracted staff (if any) to carry their own Professional Liability Insurance? ◯ Yes ◯ No

Do you secure Certificates of Insurance as evidence of such coverage? ◯ Yes ◯ No

31) What limits of Professional Liability required?

SECTION V – RISK MANAGEMENT

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

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

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

35) Do you perform pediatric dose range checks? ◯ Yes ◯ No

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

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

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

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

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

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

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

SECTION VI – CLAIMS HISTORY

43) 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? ◯ Yes ◯ No
If Yes, attach disciplinary agency documents.

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

44) 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	

45) 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

SECTION VII – GENERAL LIABILITY

46) Please list prior General Liability insurance carrier 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	

47) Please complete the following for each of your locations 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
			◯ Yes ◯ No	◯ Yes ◯ No	
			◯ Yes ◯ No	◯ Yes ◯ No	
			◯ Yes ◯ No	◯ Yes ◯ No	

48) Please complete the following for each location:

	Location 1	Location 2	Location 3
Year Built			
Year Remodeled			
Number of Stories			
Construction: Frame, Brick, Concrete			
Percentage of Building Occupied by Insured	%	%	%
Other Occupancy			

49) 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

50) Is the building equipped with:

a. Complete sprinkler system? Yes No

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

c. Self-closing fire doors on each floor? Yes No

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

e. Smoke detectors? Yes No

f. Emergency electrical system? Yes No

g. Heat sensors? Yes No

h. Fire escape(s)? Yes No

i. Posted emergency evacuation procedures? Yes No

j. Properly maintained fire extinguishers? Yes No

k. Surveillance cameras on the premises Yes No

51) Is a formal written safety program in place? Yes No
If Yes, attach a copy of the safety program.

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

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

54) Any exposure to flammables, explosives, chemicals? Yes No

55) Any exposure to radioactive materials? Yes No

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

57) Machinery or equipment loaned or rented to others? Yes No

58) 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.

59) Any parking facilities provided? Yes No

60) Does the Applicant have a full-time maintenance staff? Yes No
Please confirm the type of maintenance, service and repair performed by the Applicant (Direct) or subcontracted (Subbed).
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	%	%

61) 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

62) 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

63) Sporting or social events sponsored? Yes No

64) 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, attach a Supplemental Claim Information Form for each and every claim.

65) Has any General Liability claim or suit been brought against you and/or any of your employees? Yes No

If Yes, please complete a Supplemental Claim Information Form for each and every claim or suit.

66) 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:

67) 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:

68) PLEASE PROVIDE 5 YEARS OF CURRENTLY VALUED GENERAL LIABILITY LOSS RUNS.

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.