HEALTHCARE*Pros*
Insurance Solutions for Healthcare Service Providers

NEW ENGLAND
EXCESS EXCHANGE

P.O. Box 650 • 57 Parker Rd. • Barre, VT 05641
800-548-4301 • www.neee.com

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.

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**

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6. **STAFF:**

a. <u>NumberType of Profession</u>

________ Pharmacists

________ RNs

________ Physicians

<u>NumberType of Profession</u>

______ Pharmacy Technicians

______ Respiratory Therapists

______ Other (specify) ____________________

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 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?

____

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 HIPPA 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:

Location Number	Name and Location Address	Description of Type of Facility	Square Footage	Parking Lot or Garage Maintained by Insured?	Adjacent Exposure?
______	______________	____________	______________	☐ Yes ☐ No	☐ Yes ☐ No
______	______________	____________	______________	☐ Yes ☐ No	☐ Yes ☐ No
______	______________	____________	______________	☐ Yes ☐ No	☐ Yes ☐ 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? ❑ 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?(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 From: MM/DD/YY	Policy Period To: MM/DD/YY	Insurance Company	Limit of Liability	Deductible	Policy Form: Claims Made or 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 or 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: ______________________________________
____

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.

______________________________________/______________________ ________________________

Applicant's Signature **Title** **Date**