beazley

PHARMACY APPLICATION

NOTICE: PART OR ALL OF THE POLICY FOR WHICH THIS APPLICATION IS MADE IS WRITTEN ON A CLAIMS MADE AND REPORTED BASIS, WHICH MEANS THAT THE POLICY APPLIES ONLY TO ANY CLAIM FIRST MADE AGAINST THE INSURED AND REPORTED IN WRITING TO THE INSURER DURING THE POLICY PERIOD OR THE OPTIONAL EXTENSION PERIOD, IF APPLICABLE. AMOUNTS INCURRED AS CLAIMS EXPENSES SHALL REDUCE AND MAY EXHAUST THE LIMIT OF LIABILITY AND ARE SUBJECT TO THE DEDUCTIBLE. PLEASE READ THIS APPLICATION CAREFULLY.

BACKGROUND INFORMATION – PLEASE READ:

1. Please type or print clearly.
2. Answer ALL questions completely leaving no blanks. If any questions, or part thereof, do not apply, print N/A in the space.
3. If additional space is needed to answer any questions fully, please attach a separate page.
4. This application must be completed, dated and signed by a Principal of the Applicant.

Requested Attachments:

1. Loss History for the last FIVE years.
2. Most Recent Financial Statements.
3. Most recent local and/or State accreditation agency reports (if applicable).

I. APPLICANT INFORMATION:

a) Name of Applicant/Entity(s)____

____

b) Date of Incorporation/Start of Operations: ____

c) Physical Address (City, State, Zip Code) ____

____

d) Telephone______________________Fax___________________Website__________________

e) Legal Structure: ☐ Individual ☐ Partnership ☐ LLC
☐ Corporation ☐ Joint Venture ☐ Other______________________________

f) Tax Status: ☐ For Profit ☐ Not for Profit ☐ Governmental ☐ Other___________

g) List names, location, and descriptions of all legal entities, including subsidiaries for which Applicant is a part (continue on a separate sheet if necessary)

Loc. #	Business Name and Address	Description	Date Acquired	Ownership %	Retroactive Date

h) Does the applicant provide any services in other states/jurisdiction other than those in the above scheduled locations? .... ☐ Yes ☐ No
(If yes, please explain)

____

i) Have you sold, discontinued, or acquired any operations in the past 5 years, or do you plan to in the upcoming year? (Please list including name of entity and date acquired) .... ☐ Yes ☐ No

____

j) List all licenses held by your facility including type and expiration dates.

____

k) List any/all accreditation from governmental agencies (PCAB) and association memberships held by your facility and include a copy of your most recent report.

____

l) Are you a closed door pharmacy? .... ☐ Yes ☐ No

II. COVERAGE HISTORY:

a) Please provide details of professional liability coverage purchased in the last five (5) years to date:

Policy Period	Primary/Xs Limit	SIR/Deductible	Carrier	Annual Premium	Occurrence or Claims Made?	Retroactive Date

b) Please provide details of general liability coverage purchased in the last five (5) years to date:

Policy Period	Primary/Xs Limit	SIR/Deductible	Carrier	Annual Premium	Occurrence or Claims Made?	Retroactive Date

c) Do you currently carry employee benefits liability coverage? .... ☐ Yes ☐ No
(If yes, what is the employee count, limit, deductible, and retroactive date?)

____

d) Has the applicant ever been declined or refused coverage, or had its coverage cancelled or non-renewed? .... ☐ Yes ☐ No
(If yes, please explain)

____

III. FINANCIAL INFORMATION:

	Projected, next Fiscal/Annual Period	Past 12 Months; Most recent, full-annual	First Year Prior Financial Year:
Prescription Sales:			
Compounding Sales:			
Sundries Sales:			
Medical Equipment Sales:			
Medical Equipment Rental:			
Home Services:			
Other: ____________________			
Total:			

IV. PROFESSIONAL SERVICE/PRODUCT PROFILE:

a) Annual Number of Prescriptions Filled: ____

i. Are all prescriptions verified for specifications on patient's full name, medication name and dosage, directions for taking, physician's signature (from a licensed physician, licensed in the state where the prescription will be dispensed) and refill information?................ ☐ Yes ☐ No
(If no, Please explain)

____

ii. Is the Applicant in compliance with all local, state and federal laws that govern the manufacture, control, dispensing and distribution of prescription drugs?........... ☐ Yes ☐ No
(If no, Please explain)

____

iii. Are all prescriptions dispensed with written instructions and dispensed in appropriate containers, labelled according to state and federal regulations?........................ ☐ Yes ☐ No
(If no, Please explain)

____

iv. Are any of these dispensed prescriptions/drugs:

1) Imported from outside the United States of America?....................... ☐ Yes ☐ No
(If yes, Please explain)

____

2) Not Approved by the Food and Drug Administration?........................ ☐ Yes ☐ No
(If yes, Please explain)

____

b) Operations: (for the previous 12 months please provide a breakout of the services provided, and the percentage of total gross revenues. Total must equal 100%)

	Percentage
Compounding (please complete part VII)	
Drug Benefits	
Vaccinations	
Infusion Therapy Services (specify Adult/Pediatric)	
Veterinary Medicine	
Nuclear Medicine	
Medical Marijuana	
All Other Services: ______________________________	

c) If applicable, please provide the number of patient contacts in the previous 12 months and current projection:

(number of visits)	Projected, next Fiscal/Annual Period	Past 12 Months; Most recent, full-annual	First Year Prior Financial Year:
Clinic Visits			
Vaccinations			
Other (specify)_______________			
TOTAL VISITS			

d) Operations: (for the previous 12 months please provide a breakout of the services provided, and the percentage of total gross revenues. Total must equal 100%)

	percentage
Mail Order	
Retail	
Wholesale	
Other: ______________________________	

e) Was your facility surveyed by an accreditation agency within the past three years? ☐ Yes ☐ No
i. If "Yes", please list date(s) of last survey: ____/_____/_____

f) Does the applicant anticipate making any significant changes in the services/products provided within the next 12 months?.. ☐ Yes ☐ No
(If yes, Please explain)
____

g) Does the applicant provide any of the following services:
i. Pediatric therapy services?... ☐ Yes ☐ No
ii. Correctional facility services?... ☐ Yes ☐ No
iii. Services to Hospitals or Long Term Care Facilities?... ☐ Yes ☐ No
iv. Long Term Care Facilities?... ☐ Yes ☐ No
v. Pharmacy Benefits Management Services?.. ☐ Yes ☐ No

V. MEDICAL STAFF PROFILE:

a) Please provide details of all other staff utilized

Health Professional	Employed			Contracted		
	Full Time	Part Time	Hours	Full Time	Part Time	Hours
Pharmacists						
Pharmacy Technicians						
Nurse Practitioners						
Registered Nurses						
Other (please provide description)						

b) Are all of the above individuals registered or licensed in accordance with all applicable state and federal regulations?.. ☐ Yes ☐ No
(If yes, Please explain)
____

c) Do you require contracted staff to carry their own professional liability insurance? If yes, what are the required limits?.. ☐ Yes ☐ No
(Carrier, Limits, Deductible)
____

d) Prior to hiring any employee, does the applicant verify:
i. Education background and training?... ☐ Yes ☐ No
ii. Employment references with at least two previous employers?.................. ☐ Yes ☐ No
iii. Criminal record, on a Local, State and National scale? (Please indicate which apply)
____
iv. Driving record?.. ☐ Yes ☐ No
v. Credit record?... ☐ Yes ☐ No
vi. Drug tests?... ☐ Yes ☐ No
vii. Sex Offender Registry?.. ☐ Yes ☐ No

e) Does the applicant keep all information on file and verify its completion prior to the start of employment?.. ☐ Yes ☐ No

VI. RISK MANAGEMENT, CLAIMS HANDLING & LOSS CONTROL

a) Are there medication administration, dispensing, and storage policies/procedures in place? .... ☐ Yes ☐ No

b) Are there protocols in place for telephone/verbal orders? i.e. does the pharmacist repeat the order back to the prescriber for verification?.. ☐ Yes ☐ No

c) Are drugs with look-alike drug names stored separately and not alphabetically?...... ☐ Yes ☐ No

d) Does the applicant have access to any system, i.e. computerized drug distribution system, that would identify and/or alert the pharmacist of look-alike drug names, packaging, or labelling?... ☐ Yes ☐ No

e) How does the insured address look-alike drug names, packaging, or labelling?
____

VII. COMPOUNDING:

a) Do you compound in bulk, manufacture or wholesale medicine?.............................. ☐ Yes ☐ No
(If yes, Please explain)

____

b) Do you compound any of the following?

	percentage or compounded drugs
Chemotherapy	
Corticosteroids	
Infusion Medicine	
Lethal Injection Medicine	
Hydromorphone	
Midazolam	
Pentobarbital	
Propofol (Diprivan)	
Sodium Thiopental	
Nuclear Medicine	
Obstetrical Medicine	
Vaccinations	
Veterinary Medicine	
Other: ______________________________	

c) Is the insured registered as on outsourcing facility under the FDA - Compounding Quality Act?
.... ☐ Yes ☐ No
(If no, Please explain)

____

d) Percentage of compounded sterile prescriptions that fall into each of the USP Risk Level Determinations:

	percentage
Low-Risk Level	
Medium-Risk Level	
High-Risk Level	

VIII. INSURED HISTORY - CLAIMS, LOSSES, AND INCIDENTS:

a) Has any claim or suit for an error, omission or malpractice ever been made against you or your organization or any employees/staff working on your behalf?.................................. ☐ Yes ☐ No
If Yes, how many? _____Complete a copy of our Supplemental Claim form for each

b) Are you or any proposed insured for this insurance aware of any claim or suit, or any act, error, omission, fact, circumstance, or records request from any attorney which may result in a malpractice, general liability, or products liability claim or suit?................................. ☐ Yes ☐ No
If Yes, has each of these been reported to the current or any prior insurer?......... ☐ Yes ☐ No
How many? ______ Complete a copy of our Supplemental Claim form for each

c) Has the applicant or any staff:
i. ever been the subject of disciplinary/investigative proceedings or reprimand by a governmental/administrative agency, hospital or professional association? ☐ Yes ☐ No
ii. ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? .... ☐ Yes ☐ No
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 refuses or accepted only on special terms or ever voluntarily surrendered same? .... ☐ Yes ☐ No
(If yes, please provide an explanation on any/all incidents)

____

THE UNDERSIGNED IS AUTHORIZED BY THE APPLICANT AND DECLARES THAT THE STATEMENTS SET FORTH HEREIN AND ALL WRITTEN STATEMENTS AND MATERIALS FURINSHED TO THE INSURER IN CONJUNCTION WITH THIS APPLICATION ARE TRUE. SIGNING OF THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE INSURER TO COMPLETE THE INSURANCE, BUT IT IS AGREED THAT THE STATEMENTS CONTAINED IN THIS APPLICATION, ANY SUPPLEMENTAL ATTACHMENTS, AND THE MATERIALS SUBMITTED HEREWITH ARE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED AND HAVE BEEN RELIED UPON BY THE INSURER IN ISSUING ANY POLICY.

THIS APPLICATION AND MATERIALS SUBMITTED WITH IT SHALL BE RETAINED ON FILE WITH THE INSURER AND SHALL BE DEEMED ATTACHED TO AND BECOME PART OF THE POLICY IF ISSUED. THE INSURER IS AUTHORIZED TO MAKE ANY INVESTIGATION AND INQUIRY IN CONNECTION WITH THIS APPLICATION AS IT DEEMS NECESSARY.

THE APPLICANT AGREES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE EFFECTIVE DATE OF THE INSURANCE, THE APPLICANT WILL, IN ORDER FOR THE INFORMATION TO BE ACCURATE ON THE EFFECTIVE DATE OF THE INSURANCE, IMMEDIATELY NOTIFY THE INSURER OF SUCH CHANGES, AND THE INSURER MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS OR AUTHORIZATIONS OR AGREEMENTS TO BIND THE INSURANCE

I HAVE READ THE FOREGOING APPLICATION OF INSURANCE AND REPRESENT THAT THE RESPONSES PROVIDED ON BEHALF OF THE APPLICANT ARE TRUE AND CORRECT.

WARNING

ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT (S)HE IS FACILITATING A FRAUD AGAINST THE INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT MAY BE GUILTY OF INSURANCE FRAUD.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurer to defraud or attempt to defraud the insurer. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurer or agent of an insurer 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.

DISTRICT OF COLUMBIA: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines and an insurer may deny insurance benefits if false information materially related to a claim made by the applicant.

FLORIDA: 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 in the third degree.

LOUISIANA AND MARYLAND: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MAINE, TENNESSEE, VIRGINIA AND WASHINGTON: It is a crime to knowingly provide false, incomplete or misleading information to an insurer to defraud the insurer. Penalties may include imprisonment, fines or denial of insurance benefits.

MINNESOTA: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

OKLAHOMA: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

PENNSYLVANIA: 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.

NEW YORK AND KENTUCKY: Any person who knowingly and with intent to defraud an insurer or other person files an application for insurance or statement of claims 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. New York applicants are subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation. Pennsylvania applicants are subject to criminal and civil penalties.

Signed: ____

Date:____

Print Name: ____

Title: ____
(Owner, Partner, Authorized Officer)

If this **Application** is completed in Florida, please provide the Insurance Agent's name and license number. If this **Application** is completed in Iowa or New Hampshire, please provide the Insurance Agent's name and signature only.

Agent's Printed Name: ____

Florida Agent's License Number: _______________________________________

Agent's Signature: ____

PRIOR CLAIMS INFORMATION SUPPLEMENTAL APPLICATION

APPLICANT'S INSTRUCTIONS – PLEASE READ:

1. Please type or print clearly.
2. Answer ALL questions completely leaving no blanks. If any questions, or part thereof, do not apply, print N/A in the space.
3. If additional space is needed to answer any questions fully, please attach a separate page.
4. This supplemental application must be completed, dated and signed by a Principal of the Applicant.
5. Complete one form for each incident, claim, or suit.

a) Name of Applicant/Entity(s):____

____

b) Name of Patient/Claimant(s):____

____

c) Date(s) of Treatment:____________________ Date of Claim/Suit:_________________________

d) Claimant's Allegations:____

e) Additional Defendants:____

f) Status of Claim: ☐ Incident (negligent act, error or omission or an **Accident** that could lead to a **Claim**)
☐ **Claim** (written notice received by any **Insured** of an intention to hold the **Insured** responsible for compensation for Damages)
☐ Suit (demand, notice, summons or other process received by the **Insured** or its representative)

g) Description of Claim: (include nature of treatment and your involvement)
a. Alleged act, error of omission on which the claims is based:______________________________

____

b. Description of cases and events:____

____

c. Description of the type and extent of injury or damages allegedly sustained:_______________

____

h) Current Disposition of Claim:
☐ DISMISSED (action dropped without any payment to claimant of Statute of Limitations has expired)
☐ ABANDONED (no activity from claimant for over 3 years)
☐ WON by defense
☐ WON by claimant
Total Paid: $________________ Amount Paid on your behalf: $___________________
Please Indicate: ☐ Court judgment, or ☐ Out of court settlement

☐ OPEN Claimant's settlement demand: $_______________
Defendant's Offer for settlement: $_______________
Insurer's loss reserve: $_______________________

i) Explain what steps have been taken to prevent recurrences of similar claims:_________________

____

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Signed: ____.

Date:____

Print Name: ____

Title: ____
(Owner, Partner, Authorized Officer)

If this **Application** is completed in Florida, please provide the Insurance Agent's name and license number. If this **Application** is completed in Iowa or New Hampshire, please provide the Insurance Agent's name and signature only.

Agent's Printed Name: ____________________________________

Florida Agent's License Number: ____________________________

Agent's Signature: ____