INDIVIDUAL PROFESSIONAL LIABILITY INSURANCE APPLICATION FOR PHARMACISTS

Broker ID #_____
(Internal use only)

Code: 400636w

HOW TO APPLY:

1. You may apply on-line at **www.proliability.com/cpha or** complete application below. (Please print or type all information)
2. Visit www.proliability.com for more information and to view available professions for applying online.
3. Note the annual premium below for the policy you selected.
4. Return your completed application, along with your annual premium, to the address provided.
Coverage is effective the date your application is approved and payment is received.

PLEASE CONTACT THE PROGRAM ADMINISTRATOR AT THE TOLL FREE NUMBER PROVIDED SHOULD YOU HAVE ANY QUESTIONS REGARDING THE LIMITS AND/OR OPTIONAL COVERAGES REFLECTED.

RESIDENTS OF CALIFORNIA

NOTE: If you are a business owner and/or have employees or any independent contractors working on your behalf, please do not complete this application and instead visit www.CPhAMemberInsurance.com or call 888-926-CPhA to obtain a "Firm" application.

Section A. APPLICANT INFORMATION (REQUIRED)

First Name | **Initial** | **Last Name**

Physical Street Address (*PO Boxes Not Allowed*) | **City** | **State** | **Zip**

Mailing Address (IF DIFFERENT THAN ABOVE) | **City** | **State** | **Zip**

Business Phone # | **Fax #** | **Home Phone #**

Date of Birth (MM/DD/YYYY) | **Email Address** | **Effective Date Desired (MM/DD/YYYY)**

Fully Owned dba or Corporation (If Applicable)

Note: Businesses with employees and/or independent contractors, please visit www.CPhAMemberInsurance.com or call 888-926-CPhA to obtain a "Firm" application.

Are you an active member of the California Pharmacists Association? ☐ Yes ☐ No

Employed:

A. You are an employee of an entity and receive IRS tax form W-2 (or an unpaid volunteer). You do not have ownership in an entity that issues your W-2 and/or performs professional services for which coverage is requested.
B. Your Employer has a professional liability policy that does cover your work.

Self-Employed:

A. You either practice as an independent Solo Practitioner or as an Independent Contractor for which you receive an IRS tax form 1099 or your Employer pays your premium.
B. You must select Self-Employed if you work for an Employer that you know at the time of application does not purchase professional liability or their policy does not cover your work. You must also complete questions 2 a & b in Section B.
C. If you have or plan to hire employees and/or independent contractors and you wish to be insured for their actions, please apply as a firm. Please visit www.CPhAMemberInsurance.com or call 888-926-CPhA to obtain a "Firm" application.
D. If you work both Self Employed and Employed and would like to exclude from your coverage work you perform for **any** employer, please visit www.proliability.com/faq for further information.

Section B. UNDERWRITING QUESTIONS

1. **All Applicants:** Within the last ten (10) years:
   For all "Yes" responses, attach an explanation on a separate sheet of paper, preferably on any letterhead you might use.

a.	Have you been the subject of any disciplinary or investigative proceedings (including Medicaid billing inquiries) and/or been reprimanded by a governmental or administrative agency, hospital or professional association?	☐ Yes	☐ No
b.	Have you been convicted for an act committed in violation of any law or ordinance other than traffic offenses?	☐ Yes	☐ No
c.	Have you had practice privileges reduced, suspended OR had a license or certification to practice revoked or denied?	☐ Yes	☐ No
d.	Has any claim or suit been brought against you or are you aware of any incident that might reasonably be expected to lead to a claim or suit?	☐ Yes	☐ No
e.	Have you had professional liability coverage refused, renewal denied, and/or cancelled?	☐ Yes	☐ No

2. **Self-Employed Applicants:** Please answer each question below:

a.	Do you perform any services for or at a correctional facility? If yes, please visit www.proliability.com/faq to download and complete the required Correctional Facility Questionnaire. Your application cannot be processed without this form.	☐ Yes	☐ No
b.	Do you rent, sell, manufacture or distribute products?	☐ Yes	☐ No

Section C. PROFESSIONAL DESIGNATION

Please select your Designation, and whether Employed or Self-Employed by checking the appropriate boxes below.

Full Time (FT) = 21 + hours/week - Part Time (PT) = 20 hours/week or less

Other limit options may be available upon request, please call 888-926-CPhA or email CPhA.Insurance.service@mercer.com for more information.

NON ASHP PHARMACIST

☐ Pharmacist*

*Eligible for First Year Graduate Rates

Employed $1,000,000 / $3,000,000	Self-Employed $1,000,000 / $3,000,000
☐ FT $111 ☐ First Year Graduate $56 Date of Graduation _____	☐ FT $311 ☐ PT $156 ☐ First Year Graduate $156 Date of Graduation _____

☐ Consultant Pharmacist

Employed $1,000,000 / $3,000,000	Self-Employed $1,000,000 / $3,000,000
☐ FT $100	☐ FT $280 ☐ PT $140

☐ Pharmacist Technician

Employed $1,000,000 / $3,000,000	Self-Employed $1,000,000 / $3,000,000
☐ FT $89	☐ FT $249 ☐ PT $125

Section D. GENERAL LIABILITY

Locations must be owned or leased by the named insured. (Not available for brick and mortar practices.)

Would you like to include the optional General Liability Coverage? ☐ Yes ☐ No

If "Yes", complete the section below and attach a separate sheet if necessary.

Owned or leased premises

Address	Own or Lease?
1.	
2.	
3.	

Premium for General Liability	$1,000,000 each incident $3,000,000 annual aggregate
Coverage for 1st Location	☐ $120
Each Additional Location	☐ $50

Section E. ADDITIONAL INSURED

This coverage protects each facility under contract with the insured against claims arising out of the sole negligence of the insured.
It should only be purchased if required by contract.

Would you like to include the optional Additional Insured Coverage? ☐ Yes ☐ No

If "Yes", complete the section below and attach a separate sheet if necessary.

Name, complete physical address of landlords or entities to be named as additional insureds with coverage type and business relationship for each facility.

1. Name _____ _____ Address City State Zip Business Relationship:_____	☐ Professional Liability ONLY ☐ General Liability ONLY (GL coverage must be purchased) ☐ Professional & General Liability (GL coverage must be purchased)
2. Name _____ _____ Address City State Zip Business Relationship:_____	☐ Professional Liability ONLY ☐ General Liability ONLY (GL coverage must be purchased) ☐ Professional & General Liability (GL coverage must be purchased)

Premium for Additional Insured	$1,000,000 each incident $3,000,000 annual aggregate
Professional Liability Only	☐ $165
General Liability Only	☐ $25
Professional & General Liability	☐ $190

Section F. PREMIUM CALCULATIONS

Step 1. **PREMIUM FROM SECTION C** $_____

Step 2. **RISK MANAGEMENT CREDIT 25%** $_____
Participation or attendance at an Insurer approved loss prevention course, loss control, risk management, or legal issues seminar or other educational forum that is practice related.

Step 3. **SUBTOTAL Steps 1 and 2** $_____

Step 4: **NON-DIRECT PATIENT CARE- Check here to add the endorsement** ☐ $ **25.00**
This endorsement covers non-direct patient care services provided within your area of specialization as a Legal Consultant, Case Management, Expert Witness, Educational Services, Life Care Planning, Utilization Review, and Medical Administration. These services may not be covered under the policy without this endorsement. For more information visit www.proliability.com/faq.

Note: Consultant Pharmacists do not need to purchase this endorsement.

Step 5. **OPTIONAL COVERAGES** (Section D and E IF APPLICABLE) $_____

Step 6. **SUBTOTAL from Step 3 plus Steps 4 & 5** $_____

Step 7. **PLUS RISK PURCHASING GROUP MEMBERSHIP FEE** $ **2.00**

"Risk Purchasing Group (RPG) membership fees are used to pay for expenses related to the management and administration of the RPG, including but not limited to RPG state filings and registrations, as well as the creation of risk management and risk avoidance education materials provided to RPG members. The RPG has entered into an administrative services agreement with an affiliated entity, Mercer Health & Benefits Administration, LLC ("Mercer"), for the management and administration of the RPG, and the RPG fees will be used to pay Mercer for the administrative services it provides to and on behalf of the RPG. Please note that the RPG membership fee is subject to change based on the effective date of your policy."

Step 8. **SUBTOTAL PREMIUM** $_____

Step 9. **TOTAL DUE** (ROUND TO NEAREST WHOLE DOLLAR) $_____

I understand that I am not covered by this insurance for rendering or failure to render any professional services as a physician, surgeon, dentist, nurse midwife, perfusionist, cytotechnologist, chiropractor, podiatrist, osteopath or psychiatrist. I understand that these professional occupations are excluded from coverage. I understand that this insurance will not apply to any proprietor, owner, partner, manager, superintendent, or officer of any hospital, sanitarium, medical clinic, health maintenance organization, managed care facility, foster care agency, adoption agency, or any other facility not specified in the Declarations of the insurance policy. The insurance described herein is subject to the terms, conditions and exclusions of the insurance policy. This insurance is excess when other insurance applies to a loss.

In order to enhance the stability of this professional liability insurance program, coverage has been organized through a purchasing group, pursuant to legislation, known as the Federal Liability Risk Retention Act of 1986, enacted by Congress. Coverage is provided to the purchasing group by Liberty Insurance Underwriters Inc. ("Insurer"). This application is subject to the Insurer's underwriting rules and approval. Your completion of this application and premium payment does not bind coverage or obligate the Insurer to issue you insurance coverage. Coverage will become effective following the receipt of your acceptable application and premium payment. Your application cannot be processed unless it is completed in its entirety.

Once the completed application has been approved and the premium has been received, you will automatically become a member of a risk purchasing group operated by Mercer that is consistent with your professional designation.

INSURANCE FRAUD WARNINGS

IN ALL STATES OTHER THAN THOSE LISTED BELOW: 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 may be a crime and may subject the person to criminal and civil penalties.

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

COLORADO: 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.

DISTRICT OF COLUMBIA: WARNING: 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. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided 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 of the third degree.

KANSAS: 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.

KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

MAINE, TENNESSEE, VIRGINIA AND WASHINGTON: 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 or denial of insurance benefits.

MARYLAND: Any person who knowingly or 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.

NEW JERSEY: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NEW MEXICO: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

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 concerning 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.

OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OKLAHOMA: WARNING: 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.

YOU MUST SIGN AND DATE THIS APPLICATION

Declaration and Signature -

The undersigned declares to the best of his/her knowledge and belief that the statements contained herein are true and are the basis of the acceptance of the risk or the hazard assumed by the Insurer under this Policy. It is further agreed by the undersigned, that the Policy, if issued, is in reliance upon the truth of such representations. It is agreed that, although the signing of the Application does not commit the undersigned to purchase the insurance being applied for, the statements made in this Application shall become the basis of the Policy should one be purchased. The Insurer is hereby authorized to make any investigation and inquiry in connection with this Application deemed necessary.

_____ _____ / _____ / ____

Applicant Signature **Date**

_____

Name of individual signing this application (printed)

Enclosed is my check for $_____

Make check payable to Mercer and return your check and this application.

May not be earlier than the date the Program Administrator receives and approves this application.

If you choose to pay by credit card, visit https://mercer-web.com/cpha to enter your credit card information and upload this form*. Submission of your credit card information to Mercer does not constitute receipt of payment or approval or binding of coverage by the insurer. Any coverage is subject to the terms and conditions of the insurance policy issued by the insurer. Payment will be processed upon review and acceptance of your submission.

**Note: Credit card payments are not accepted by email or fax.*

Section Below For Producer/Agency Information Only

_____ _____ _____/ _____/ _____

Producer's Signature **roducer's License Number** **Date**

_____

Producer's Name

AMBA

Program Administered by:
Association Member Benefits & Insurance Agency
P.O. Box 78001
Minneapolis, MN 55480

https://www.cphamemberinsurance.com

CA Insurance License #0I96562

Underwritten by: Liberty Insurance Underwriters Inc.