Liberty International Underwriters

400636w

Professional Liability Insurance Application for Pharmacist Practices/Groups

For the purposes of this application and answering the following questions, the terms 'business' and 'entity' refer to your entire operation including all business owners, partners, officers, employees, independent contractors and volunteers.

1. APPLICANT INFORMATION

Practice Name (include any doing business as names)_____

_____

Physical Mailing Address (PO *Boxes are not accepted*)

_____

City State Zip

Are all services provided from this location? ☐ Yes ☐ No
If "No," please provide additional locations:

_____

_____

Phone: _____ Fax: _____

Website: _____ E-mail: _____

Contact Name:_____ Title: _____

Contact Phone Number: _____ Date Established: _____ FEIN/Tax ID#: _____

Requested Effective Date of Policy: _____ / _____ / _____ (Must be within 60 days following application date.)

Are you an active member of California Pharmacists Association (CPhA) ☐ Yes ☐ No

Business is a: ☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Limited Liability Corporation
☐ Professional Association ☐ Other: _____

Names of Business Owners:

_____

_____

Please describe the ownership structure of your business (i.e. Owned 75% by Jane Doe, 25% by John Doe):

_____

2. PERSONNEL SECTION

A. OWNERS:

NAME	Professional Occupation	List All Specialties/Licensures/ Certifications	HOURS WORKED PER WEEK
1.			
2.			
3.			
4.			
5.			
6.			

B. EMPLOYEES/INDEPENDENT CONTRACTORS:
Designation Codes* E-Employee IC-Independent Contractor

NAME	*Employment Status	PROFESSIONAL OCCUPATION (Include any specialty/licensure/ certification if applicable)	HOURS WORKED PER WEEK
1.			
2.			
3.			
4.			

3. EXPOSURE INFORMATION

A. Please provide the annual gross revenue for your entity. Gross revenue is inclusive of all compensation for the delivery of professional services before expenses, taxes, or other business costs are deducted.
Prior twelve (12) months: $_____ Projected next twelve (12) months: $_____

B. Number of prescriptions filled for prior twelve (12) months: $_____ Projected next twelve (12) months: $_____

C. Does your entity rent or sell products?* ☐ Yes ☐ No
If "Yes", describe products and provide percentage of revenue derived from sales

_____

* Please note coverage may not be available for this exposure. Please contact program administrator for more information.

D. Practice Settings: Please provide the percentage of your entities work performed at each of the following settings (total of all percentages must equal 100%). Additionally, please describe your entities relationship with the facility type. (For example, if you own or operate a clinic place the letter "O" in the box to the left of "Clinic". If you own one clinic and have a contract with another, place "O" and "C" in the box to the left.)

Owned/ Operating (O) Contracted(C)	Type of Facility	Average Time/Week	Owned/ Operating (O) Contracted(C)	Type of Facility	Average Time/Week
	Closed Door Pharmacy	%		Hospital	%
	Community Based Pharmacy	%		Long Term Care	%
	Correctional Facility	%		Nursing Home	%
	Educational Institution	%		Outpatient Clinic	%
	Other Miscellaneous Facility (Please Describe) _____				%

E. Do you work in a facility considered retail, big box, such as a Wal-Mart, etc.? ☐ Yes ☐ No
If "Yes", please provide location(s):_____

F. List all states where prescriptions are filled by your entity: _____

G. Please describe the nature of your entity's operations in percentages (must total 100%)
- ☐ Retail: _____ %
- ☐ Wholesale: _____ %
- ☐ Mail Order: _____ %
- ☐ Drug Benefit: _____ %
- ☐ Compounding _____ % What portion is sterile compounding _____%
- ☐ Closed Pharmacy: _____ %
- ☐ Other: _____%

Describe: _____

H. Does your entity, or anyone affiliated with your entity, perform any clinical services (diagnoses, vaccinations, etc.)? ☐ Yes ☐ No
If so, please describe services_____

I. Do any of your entities employed or contracted staff provide any services as an attorney, accountant or financial planner? ☐ Yes ☐ No
If "Yes", please attach a detailed description.

J. Do any of your entities employed or contracted staff provide any Case Management Services, Consulting Services, Educational Services, Life Care Planning, or Utilization Review? ☐ Yes ☐ No
If "Yes," please provide the number of owners, employed or contracted staff engage in these services:_____

4. RISK MANAGEMENT / LOSS CONTROL

Is your entity accredited by a national healthcare accreditation organization (i.e.: AAAHC, JCAHO, NCQA, etc.)? ☐ Yes ☐ No
If "Yes," please specify:_____

A. Please list any risk management certifications held by any owners, partners, officers or employees. If not applicable mark N/A: ☐ N/A

_____

_____

Do at least 50% of the entity's owners, partners, officers and employees hold the certifications referenced above? ☐ Yes ☐ No

B. Does the entity ever dispense non-FDA approved drugs? ☐ Yes ☐ No
If "Yes", please provide details of the drugs/medications: _____

_____

_____

C. Is a unit-dose system used in the organization? ☐ Yes ☐ No

D. Does your entity conduct background checks on all employees and independent contractors prior to hiring? ☐ Yes ☐ No
If 'Yes" please provide a description of types of background checks performed and by whom: _____

_____

E. Regarding the entity's computer system:

1. Does your entity utilize a computer system to detect drug contraindications, interactions, duplications against medical history and other prescribed drugs? ☐ Yes ☐ No
   If "Yes", please provide details:
   System Name: _____
   Name of vendor: _____
   Are special alerts built into the system concerning problematic or look-alike drug names, packing or labeling? ☐ Yes ☐ No
2. How often do you back up your computer systems? _____
3. What software or vendor do you use for internet security? _____
4. Does your internet security system include:
   - Protection against viruses, worms and other malware with regular updates provided by the manufacturer? ☐ Yes ☐ No
   - Firewall protection? ☐ Yes ☐ No
5. Has your entity ever had a computer system and/or hardware hacked into, stolen or otherwise tampered with? ☐ Yes ☐ No
   If "Yes", please provide details: _____

   _____

   _____

F. Are all prescriptions dispensed with current written instructions? ☐ Yes ☐ No

G. Is the entity in compliance with all local, state and federal laws that govern the manufacture, control, dispensing and distribution of prescription drugs? ☐ Yes ☐ No

H. Does your entity have procedures in place to report errors to a third party Patient Safety Organization (PSO) such as the Institute for Safe Medication Practices (ISMP)? ☐ Yes ☐ No

I. Does your entity accept electronic prescriptions? ☐ Yes ☐ No
If "Yes", what safety controls are in place to assure prescriptions are prescribed by licensed physicians? _____

_____

_____

J. Does your entity have the following procedures in place?

1. A formalized risk management program? ☐ Yes ☐ No
2. A formalized program for protection of patient information/HIPAA compliance? ☐ Yes ☐ No
3. A formalized CMS compliance program? ☐ Yes ☐ No
4. Background checks on all employees and independent contractors prior to hiring? ☐ Yes ☐ No

K. Does your entity use medical equipment in the performance of your professional services? ☐ Yes ☐ No
If "Yes," does your entity have a formal medical equipment maintenance program in place that includes the following?

1. Proper training of all equipment users? ☐ Yes ☐ No ☐ N/A
2. Controls over staff owned equipment? ☐ Yes ☐ No ☐ N/A
3. Repairs by qualified personnel? ☐ Yes ☐ No ☐ N/A
4. Policies and procedures for borrowing, lending, selling or donating equipment? ☐ Yes ☐ No ☐ N/A
5. Documentation of all activities (preventative maintenance, repairs, education? ☐ Yes ☐ No ☐ N/A

L. Does your entity have procedures in place to address drug/alcohol abuse/dependency among employees and independent contractors? ☐ Yes ☐ No
If so, please describe: _____

M. Do you ensure that all pharmacists and other professionals, required to be licensed and/or certified in the state(s) in which you provide services, maintain their licensure and/or certification? ☐ Yes ☐ No ☐ N/A
If no, please explain_____

5. CLAIMS & DISCIPLINARY ACTIONS

A. Within the last ten (10) years has your entity or anyone affiliated with your entity?

1. Been the subject of disciplinary or investigative proceedings and/or been reprimanded by a governmental or administrative agency, hospital or professional association? ☐ Yes ☐ No
2. Been convicted for an act committed in violation of any law or ordinance other than traffic offenses? ☐ Yes ☐ No
3. Had any state professional license or license to prescribe or dispense narcotics refused, reduced? Suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered? ☐ Yes ☐ No
4. Had privileges reduced, suspended or revoked? ☐ Yes ☐ No
5. Been denied a license or certification to practice? ☐ Yes ☐ No
6. Had Medicare or Medicaid authorities initiate an investigation into alleged billing fraud and abuse directed at you or any employee? ☐ Yes ☐ No

If "Yes" to any of the above questions, please explain in full detail by attachment.

B. Does your entity verify pending license suspensions, revocations or pending disciplinary actions involving current/future employees or independent contractors? ☐ Yes ☐ No

C. Within the last ten (10) years, has a claim or suit been brought against your entity or anyone affiliated with your entity, or are you aware, after inquiry of anyone to whom this insurance is intended to apply, of any incident that might reasonably be expected to lead to a claim or suit? ☐ Yes ☐ No
If "Yes", please visit www.proliability.com/faq to complete the Claim Supplemental Questionnaire for each claim and/or incident.

D. Within the last ten (10) years has your entity or anyone affiliated with your entity had professional liability coverage refused, renewal denied and/or cancelled?* ☐ Yes ☐ No
*If "Yes", please provide copy of the notice of declination, non-renewal or cancellation.

6. PRIOR INSURANCE

***No Prior Acts Coverage Available*

Insurance Carrier	Limits	Effective Date	Annual Premium	Claims Made** or Occurrence	Retro-Active Date

7. Additional Coverage Requested*

* subject to additional premium charge

For more information on General Liability and Additional Insureds, please visit www.proliability.com/faq

☐ **General Liability**: **Property Locations must be owned or leased by the named insured. (**Coverage is not available for brick and mortar pharmacies.)

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

Address	Own or Lease?
1.	
2.	
3.	

☐ **Additional Insured:**

This optional 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.***

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:	☐ Professional Liability ONLY ☐ General Liability ONLY (GL coverage must be purchased) ☐ BOTH Professional and General Liability (GL coverage must be purchased)
Address:	
City: State: Zip:	
Business Relationship:	

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

8. Please read carefully and sign and date where indicated on the last page.

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 does not bind coverage or obligate the Insurer to issue you insurance coverage. 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 AMBA 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, on behalf of all prospective insureds, after a reasonable inquiry, 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, its Subsidiaries and their directors, officers and trustees 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.

_____ _____ _____ / _____ / ____

Signature of Authorized Partner / Officer/Owner **Title** **Date**

_____

Name of individual signing this application (printed)

Section Below For Producer/Agency Information Only

_____ _____ _____/ _____/ _____

Producer's Signature Producer's License Number Date

_____

Producer's Name

☐ If you are interested in learning more about other lines of coverage that may be available to you through the program administrator (i.e. Business Owners Package, Workers' Compensation, Medical, etc.) please check the box or call the program administrator at 888-926-CPhA.

Premiums will be calculated by the Client Advisor. Minimum premium of $300.

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.