ADMIRAL INSURANCE COMPANY

PHARMACY PROFESSIONAL LIABILITY INSURANCE

1. **GENERAL INFORMATION**

   a. Full Name of Applicant:_____

   b. Principal Address (List Additional Locations on a Separate Sheet):

   _____

   _____

   c. Mailing Address:_____

   _____

   d. Date Established:_____

2. **OPERATIONS**

   a. Describe the nature of applicant's operations including types and percentage of services rendered:

Retail	_____%
Wholesale	_____%
Mail Order	_____%
Drug Benefit	_____%
Compounding	_____%
Other	_____% _____
Total	100%

   b. Provide the following information for all of the States in which you are licensed:

State	**License No.**	**Effective Date**	**Expiration Date**

   c. Are all drugs dispensed FDA approved? Yes_____ No_____ If no, please attach an explanation.

   d. Complete the following information for each location you own.

Name & Address	**Your Ownership %**	**Description of Operations**

e. Do you have any International Operations? Yes_____ No_____

f. Are any drugs imported? Yes_____ No_____ If yes, please attach an explanation.

g. Does a license physician in State where services are rendered issue all prescriptions? Yes_____ No_____

h. Is pharmacy in compliance with all local, state and federal laws that govern the manufacture, control, dispensing and distribution of prescription drugs? Yes_____ No_____

i. Annual Number of prescriptions filled _____

j. 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	$_____	$_____

k. Is the applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPPA) Privacy rule? Yes_____ No_____

l. If yes,
(i) Has the Applicant implemented procedures to comply with the HIPPA Privacy Rule? Yes___ No___
(ii) Provide the name and title of the Applicant's Privacy Officer: _____

3. **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 Home _____ Hospitals _____ Extended Care Facility _____ Correctional Facilities _____
MCO's _____ If yes, please provide a copy of the 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 equipment** you sell or lease or repair for others:

Type	Annual Sales	Last 12 Months	Current 12 Months

4. **STAFF**

a.

Number	Type of Profession	Number	Type of Profession
_____	Pharmacists	_____	Pharmacy Technicians
_____	RNs	_____	Respiratory Therapists
_____	Physicians	_____	Other _____

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 the 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 Professional Liability are required?_____

5. **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. Are products with known look-alike drug names stored separately and not alphabetically? Yes_____ No_____

c. Do you have access to drug information? (i.e. Drug Facts and Comparisons, Micromedex etc.)? Yes_____ No_____

d. Do you perform pediatric dose range checks? Yes_____ No_____

e. How do you detect drug contradictions, interactions, duplications against medical history and other prescribed drugs? _____

f. What safety controls are in place to address problematic or look-alike drug names, packaging or labeling? _____

g. Are special alerts built into the system concerning problematic or look-alike drug names, packaging or labeling? Yes_____ No_____

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

i. Are all prescriptions dispensed with current written instructions? Yes_____ No_____

j. Do you accept electronic prescriptions? Yes_____ No_____ If yes, what safety controls are in place to assure prescriptions are prescribed by licensed physicians? _____
_____

k. How are drug wastes and expires drugs disposed of? _____
_____

6. **APPLICANT HISTORY/CLAIMS**

a. have you or any of your employees:
   (i) Ever been the subject of disciplinary or investigative proceedings or reprimanded 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___

b. Please list Professional Liability Insurance carried for each of the past five years. If none, state none.

Insurance Carrier	Policy Number	Limits of Liability	Deductible	Premium	Inception Mo./Day/Yr.	Claims Made? Yes	No	Retro Date

c. Has any claim or suit been brought against you and/or any of your employees? Yes_____ No_____
If yes, please provide the following information:

1. If a current loss summary is available from the present and previous carrier, please attach a copy.
2. If a loss summary is not available, attach a Supplemental Claim information Form showing the following information for each claim:
   (i) Date of event and date claim was reported to the insurance company
   (ii) Description (cause) or loss or claim
   (iii) Location of loss
   (iv) Current status (open or closed)
   (v) Paid amount and current reserve amount
3. Are you aware of any circumstances which may result in a malpractice claim or suite being made or brought against you or any of your employees? Yes_____ No_____
   If yes, attach details.

d. Please list prior General Liability Insurance carried for each of the past five years. If none, state none.

Insurance Carrier	Policy Number	Limits of Liability	Deductible	Premium	Inception Mo./Day/Yr.	Claims Made? Yes	No	Retro Date

7. GENERAL LIABILITY

a. 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___	_____

b. Please complete the following for each location:

(i) Year Built	_____	_____	_____
(ii) Year Remodeled	_____	_____	_____
(iii) Number of Stories	_____	_____	_____
(iv) Construction: Frame, Brick Concrete	_____	_____	_____

(v)	Percentage of Building Occupied by Insured	_____	_____	_____
(vi)	Other Occupancy	_____	_____	_____
(vii)	Location Number	_____	_____	_____

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)	Automatic fire alarm system connected to local fire department?	Yes___ No___
(v)	Smoke detectors?	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, explosives, chemicals? Yes___ No___

g. Any catastrophe exposure? 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. Machinery or equipment loaned or rented to others? Yes___ No___

k. Are there any elevators or escalators owned by you? Yes___ No___
If yes, please indicate model and if the elevator and/or escalator is services by you under a maintenance contract.

l. Any parking facilities provided? Yes___ No___

m. Recreation facilities provided? Yes___ No___

n. Is there a swimming pool on the premises Yes___ No___

o. Sporting or social events sponsored? Yes___ No___

10 year General Liability Loss History (attach further sheets if needed)

p.	Date of Occurrence	Date Claim Made	Amount Description of Loss	Amount of Loss Reserved	Amount Expenses Paid	Open (O) Expenses Reserved	or Closed (C)

q. 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, please attach a Supplemental Claim Form

NOTICE TO APPLICANT: The coverage applied for is SOLELY AS STATED IN THE POLICY, which provides coverage on a "CLAIMS MADE" basis for ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD unless the extended reporting period option is exercised in accordance with the terms of the policy.

WARRANTY: I/We warrant to the insurer, that I understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy of insurance and deemed incorporated herein, should the Insurer evidence its acceptance of this application by issuance of a policy. I/We authorize the release of claim information from any prior Insurer to Admiral Insurance Company.

_____	_____
Name of Applicant	Title (Officer, partner, etc.)
_____	_____
Signature of Applicant	Date

SIGNING this application does not bind the Applicant or the Insurer to complete the insurance, but one copy of this application will be attached to the policy, if issued.