PROFESSIONAL LIABILITY APPLICATION
For
PHARMACIST/PHARMACY

INSTRUCTIONS: **Answer all questions. If the answer is none, state "NONE". If the question is not applicable, state "Not Applicable (N/A). If the space proved is insufficient to fully answer the question, attach a separate sheet. Application must be dated, signed by owner, partner, officer or administrator. Please type or print in ink & please DO NOT REDUCE when faxing.**

GENERAL INFORMATION

1.2 Applicant Name:
1.3 Mailing Address:
1.4 Location Address:
1.5 County (Parish) Of Each Location:
1.6 Telephone Number: Fax:
1.7 Person To Contact For Survey: Name Title
1.8 PROPOSED EFFECTIVE DATE: Year entity established:
1.9 The Applicant Is [Please Check And Complete A) Or B) Below]:
A. The APPLICANT is an INDIVIDUAL: Employee Student Sole Practitioner
B. The APPLICANT IS A : Sole Proprietorship Partnership Corporation
Other – Describe
1.10 Entity is For Profit Non-Profit (Source of Funds:)
1.11 Requested Limits of Liability (if available): $ /$ (aggregate)
1.12 If General Liability Coverage Also Desired: $ /$ (aggregate)
1.13 Annual Gross Receipts: Estimated for Next 12 Months (complete all categories applicable)

[1] Complete Products Sales/Rental Supplement
[2] Complete Home IV Supplement

From Prescription Sales: $
From Sundries Sales: $
From Medical Equipment Sales[1]: $
From Medical Equipment Rental[1]: $
From In Home I.V. Therapy[2]: $
Other $
(Total Receipts Last 12 Months $) TOTAL $
1.14 Total Premises Square Footage Occupied By Applicant (Own/ Lease)
1.15 If any off premises operations, describe:

NOTICE

THIS POLICY (IF ISSUED) IS ISSUED BY YOUR RISK RETENTION GROUP. YOUR RISK RETENTION GROUP MAY NOT BE SUBJECT TO ALL THE INSURANCE LAWS AND REGULATIONS OF YOUR STATE. STATE INSURANCE INSOLVENCY GUARANTY FUNDS ARE NOT AVAILABLE FOR YOUR RISK RETENTION GROUP.

EXPOSURES

2.1 Service is licensed as:

2.2 Describe the nature of applicant's operation, including types of services rendered and activities conducted:

2.3 List all memberships in professional organizations:

2.4 Total number of ALL staff:
Number of Professional Staff: (E = Employed; C = Contracted)

E	C		E	C	
		Pharmacists			Pharmacy Technicians
		RN			LVN/LPN
		Respiratory Therapists			Laboratory Technicians
		Other			Other
		Other			Other
		Physicians	(Physicians required to carry own professional liability insurance at equal limits. Complete Physician Exposure Supplement).		

2.5 Total remuneration paid to all staff: (employee or contract) Est. Next 12 months: $
Actual Last 12 months: $

2.6 Do you require:
A) Contracted staff (if any) to carry their own Professional Liability Insurance and secure Certificates of Insurance as evidence of such coverage? Yes No
B) Employed or contracted physicians, surgeons, nurse anesthetists, dentists, podiatrists or chiropractors to carry their own Professional Liability Insurance and secure Certificates of Insurance as evidence of such coverage? Yes No
What minimum limits of Professional Liability are required?

RISK MANAGEMENT

3.1 **If Applicant is Employed or Contract INDIVIDUAL**, give name and address of all EMPLOYERS, nature of employer's operations, name of direct supervisor, describe your duties.

Does Employer require you to carry the insurance being applied for? Yes No
Does Employer carry own professional liability insurance? Yes No

3.2 **If Applicant is a Business Entity,** give name of Administrator/Supervisor and describe his/her training and experience.

3.3 Do you enter into contractual agreement to provide professional services? Yes No

3.4 Do you require staff to report all incidents (accidents) which might result in a liability claim AND are records of such reports kept on file by you: Yes No
If not, are you agreeable to instituting this procedure? Yes No

3.5 **Enclose a copy of all brochures** or advertising materials distributed by you.

3.6 Describe any "fund raising" or other special events activities conducted.

3.7 Do you rent, sell or otherwise provide any equipment or products to others: Yes No
IF YES, complete our Products Supplement.

3.8 Do you have any other premises or operations exposures not stated in this application, or an interest in any other Healthcare Services businesses? Yes No
IF YES, enclose complete description and underwriting/rating information, including insurance coverage for that operation (Professional and General Liability), including carrier, limits, etc.

HISTORY

4.1 List Prior Professional Liability Insurers For The Past Five Years, Starting With The Most Recent Year. If None, So State.

	Insurer	Limits of Liability	Premium	Effective Date	Claims Made Form	
					Yes	No
1.						
2.						
3.						
4.						
5.						

If Claims-Made Form, What Is The Most Recent Retroactive Date:

4.2 List Prior General Liability Insurers For The Past Five Years, Starting With The Most Recent Year. If None, So State.

	Insurer	Limits of Liability	Premium	Effective Date	Claims Made Form	
					Yes	No
1.						
2.						
3.						
4.						
5.						

If Claims-Made Form, What Is The Most Recent Retroactive Date:

4.3 Have any claims been made or occurrences reported during the past six years against any of proposed insureds or against any entity that any proposed insured has or has had an interest?
Yes No IF YES, please describe, indicate status of the claim or suit, and any amount(s) paid or reserved (attach an additional sheet if necessary).

4.4 Does any proposed insured have any knowledge of an event, circumstance or occurrence (other than any listed in 4.3 above) prior to the effective date of the proposed policy, or does any proposed insured foresee that a claim may be brought as a result of said event, circumstance or occurrence? Yes No IF YES, describe the event and indicate the reason for anticipation of a claim.

I understand and agree this Application and any and all supplements attached hereto may be made a part of any policy issued, and any such policy will be issued in reliance upon the representation made herein. I further understand and agree that failure to provide a true and accurate response to the foregoing questions may, at the option of the Company, result in the voiding of insurance issued in reliance on this Application and/or denial of claims under any policy issued.

I authorize and consent to investigations of information bearing upon moral character, professional reputation and fitness to engage in the activities of my business including authorization to every person or entity, public or private, to release to the company providing insurance coverage and Mid-Continent General Agency, Inc. any documents, records or other information bearing upon the foregoing.

I understand and agree these investigations shall not be confined to information submitted in this application, but shall include any other sources of information deemed relevant by the Company as may be authorized by law.

Applicant and all owners, employees, and contractors are licensed or duly authorized in all states or jurisdictions where professional services are provided. Applicant warrants the truth of all answers to the above questions, and that applicant has not withheld any information which is calculated to influence the judgment of the insurance company in considering this application.

IMPORTANT: THIS APPLICATION MUST BE SIGNED BY THE APPLICANT. SIGNING THIS FORM DOES NOT BIND THE COMPANY TO COMPLETE THE INSURANCE.

Date

Applicant / Title

Supplemental information:
(please reference any questions you are referring to)