PO Box 768 · Hendersonville, TN 37075
(T) 800-768-7475 · (F) 615-264-3980
www.bsrins.com

HISCOX

Pharmacy
Mainform Application

Applicant Information

1. Applicant name:

2. Principal business address (attach separate sheet if more than one location):

3. Telephone number:

4. Date established:

5. Applicant's practice is a:

☐ Solo practitioner (unincorporated)	☐ Solo practitioner (incorporated)
☐ Corporation (for-profit)	☐ Corporation (non-profit)
☐ Professional Association	
☐ Other (please describe):	

Operations and Activities

6. Indicate the percentage of the applicant's operations by type:

Retail	%	Wholesale	%	Mail order	%
Drug Benefit	%	Compounding	%		
Other – please describe:					%

7. Annual number of prescriptions filled:

Last 12 months: Next 12 months:

8. Annual gross receipts:

	in last 12 months	for next 12 months
Prescription sales	$	$
Sundries sales	$	$
Medical equipment sales	$	$
Medical equipment rental	$	$
In-home therapy	$	$
Other – specify:	$	$

9. Does the applicant have any international operations? Yes ☐ No ☐

10. Does the applicant provide services to any of the following: nursing home, hospital, extended care facility, correctional facility, MCO? Yes ☐ No ☐
If Yes, please provide a copy of the contract.

11. Does the applicant 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 a list of the five largest clients and provide a copy of a sample contract.

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Staffing Information

12. a. Please indicate the number of employed and contracted staff:

Profession	Employed	Contracted
Pharmacists		
Nurses		
Pharmacy technicians		
Respiratory therapists		
Respiratory therapists		
Physicians		
Other – specify:		

i. Are all the above individuals registered or licensed in accordance with all applicable state and federal regulations? Yes ☐ No ☐

If No, please explain in the comments section.

ii. Do you require contracted staff to carry their own professional liability insurance? Yes ☐ No ☐

iii. Do you maintain Certificates of Insurance to confirm such coverage? Yes ☐ No ☐

b. Has the applicant or have any of the above employees:

i. ever been the subject of disciplinary or investigative proceedings or reprimand 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 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 refused or accepted only on special terms or ever voluntarily surrendered same? Yes ☐ No ☐

If Yes to any of the above, please explain in the comments section.

c. Provide the name of the applicant's Medical Director and attach a copy of his/her Curriculum Vitae (CV).

Risk Management Procedures

13. Are any drugs imported? Yes ☐ No ☐

14. Are all the drugs dispensed FDA approved? Yes ☐ No ☐

15. Are there medication administration policies/procedures in place? Yes ☐ No ☐

16. Are there medication dispensing policies/procedures in place? Yes ☐ No ☐

17. Are there medication storage policies/procedures in place? Yes ☐ No ☐

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18. Are there protocols for appropriate packaging for delivery to patients in order to maintain the integrity and correct temperature of medications? Yes ☐ No ☐

19. Are there quality checks to ensure delivery of medications to the right place? Yes ☐ No ☐

20. Are there communication protocols for verification of telephone/verbal orders? Yes ☐ No ☐

21. Are there communication protocols for questionable medication orders? Yes ☐ No ☐

22. Are there security access measures for controlled drugs and medications? Yes ☐ No ☐

23. Are there policies/procedures in place for the use, administrations, and proper disposal of radio-pharmaceuticals? Yes ☐ No ☐

Insurance and Claims History

24. Has any similar insurance ever been declined or cancelled? Yes ☐ No ☐

If Yes, please explain in the comments section.

25. Does any person to be insured have knowledge or information of any act, error, or omission which might reasonably be expected to give rise to a claim against him/her? Yes ☐ No ☐

If Yes, please attach complete details including a description of the incident(s).

26. After inquiry have any claims been made against any proposed Insured(s) during the past five (5) years? Yes ☐ No ☐

If Yes, please complete a supplemental claims information form for each claim.

27. How many claims have been made in the last five (5) years? ☐

28. a. List prior professional liability insurers for the past five years (if none, please tick box) ☐

Insurer	Dates covered from-to (mm/dd/yy)	Limits of liability per claim / aggregate	Deductible	Premium	Coverage type: occurrence or claims-made
		/			
		/			
		/			
		/			
		/			

b. If the current/expiring policy is on a claims-made form, what is the retroactive date? ☐

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29. a. Is the applicant currently insured under a commercial general liability policy including products and completed operations coverage? Yes ☐ No ☐

Insurer	Dates covered from-to (mm/dd/yy)	Limits of liability per claim / aggregate	Deductible	Premium	Coverage type: occurrence or claims-made
		/			
		/			
		/			
		/			
		/			

b. If the current/expiring policy is on a claims-made form, what is the retroactive date?

Comments Section

It is understood and agreed that with respect to questions 21 and 22, that if such knowledge or information exists any claim or action arising there from is excluded from this proposed coverage.

Notice to New York applicants: any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any false information, or conceals for the purpose of misleading, information concerning any material thereto, commits a fraudulent insurance act, which is a crime.

The applicant hereby acknowledges that he/she/it is aware that the limit of liability shall be reduced, and may be completely exhausted, by the costs of legal defense and, in such event, the Insurer shall not be liable for the costs of legal defense or for the amount of any judgment or settlement to the extent that such exceeds the limit of liability.

The applicant further acknowledges that he/she/it is aware that legal defense costs that are incurred shall be applied against the deductible amount.

I DECLARE that, after inquiry, the above statements and particulars are true and I have not suppressed or misstated any material fact and that I agree that this application shall be the basis of the contract with the Underwriters.

Name of applicant:

Signature of person authorized to execute on behalf of the applicant:

Name/title of person authorized to execute on behalf of the applicant:

Date:

This application form duly completed, together with any supplementary information, must be signed in ink or by electronic signature by the person indicated. Signing of this form does not bind the applicant or the Underwriters to complete this insurance.
A copy of this application should be retained for your records.