SPG SPECIALTY PROGRAM GROUP

HUDSON EXCESS INSURANCE COMPANY PHARMACY APPLICATION

SECTION 1: APPLICANT INFORMATION

Firm's Full Legal Name, Include Any DBA: _____

Primary Practice Address: _____ City/State/Zip: _____

Address for Additional Locations: ☐ No Other Locations _____

Primary Telephone Number: _____ Email Address: _____

Web Address: _____

Date Established:_____ Risk Manager Contact: _____

SECTION 2: INSURANCE HISTORY

Professional liability insurance history: ☐ Check here if you are buying coverage for the first time.

Policy Year	Professional Liability Carrier	Limits of Insurance	Deductible	Retro Date*	Premium
Expiring Policy					
One Year Prior					
Two Years Prior					

*If retroactive coverage is requested, we will need a copy of currently valued loss runs and the expiring declaration page for proof of expiring limits and retroactive coverage, prior to binding.

Coverage Requested:

- ☐ Professional Liability
- ☐ General Liability (Occurrence)
- ☐ General Liability (Claims-Made): Retroactive Date:_____
- ☐ Hired & Non-Owned Auto
- ☐ Stop Gap
- ☐ Physical & Sexual Abuse: Limit Requested:_____
- ☐ Employee Benefits Liability: Retroactive Date:_____
- ☐ Business Personal Property (BPP): Limit Requested:_____
- ☐ Employee Theft (3rd Party Liability): Limit Requested:_____

SECTION 3: SERVICES PROFILE

1. Type of Services provided (check all that apply):

- ☐ Retail Pharmacy Services ____%
- ☐ Mail Order Services ____%
- ☐ Veterinary Services ____%
- ☐ Immunizations _____
- ☐ Wholesale Services ____%
- ☐ Closed Door Services ____%
- ☐ Nuclear Services ____%
- ☐ Vaccinations _____
- ☐ Sterile Compounding ____%
- ☐ Non-Sterile Compounding ____%
- ☐ Pharmacy Benefits Management
- ☐ Other Services_____%

2. Total annual gross revenues (projected):

- ☐ $0 to $3,000,000
- ☐ $3,000,001 to $4,000,000
- ☐ $4,000,001 to $5,000,000
- ☐ $5,000,001 to $6,000,000
- ☐ $6,000,001 to $7,000,000
- ☐ $7,000,001 to $8,000,000
- ☐ $8,000,001 to $9,000,000
- ☐ $9,000,001 to $10,000,000
- ☐ $10,000,001 to $11,000,000
- ☐ $11,000,001 to $12,000,000
- ☐ $12,000,001 to $13,000,000
- ☐ (Greater than $13m):_____

3. Annual number of prescriptions filled (projected):

- ☐ 0 to 25,000
- ☐ 25,001 to 40,000
- ☐ 40,001 to 55,000
- ☐ 55,001 to 70,000
- ☐ 70,001 to 85,000
- ☐ 85,001 to 100,000
- ☐ 100,001 to 115,000
- ☐ 115,001 to 130,000
- ☐ (Greater than 130,000):_____

4. Past 12 months:

☐ Annual Gross Revenues: _____ ☐ Annual number of prescriptions filled:_____

5. Does the insured provide services to (check all that apply):

☐ Hospitals	☐ Medical Clinic	☐ Adult Day Care Facilities
☐ Nursing Homes	☐ Correctional Facilities	☐ Research Facility
☐ Assisted Living Facilities	☐ In-Home (patients)	☐ Other:_____

6. Accreditation and Licensure:

Has the insured been surveyed within the past three years by the National Association of Boards of Pharmacy (NAPB) for accreditation?	☐ Yes	☐ No
Is the insured a member of the Institute for Safe Medication Practices (ISMP)?	☐ Yes	☐ No

SECTION 4: TYPES OF PHARMACEUTICALS DISPENSED

1. Opioids:

Does the insured fill prescriptions for opioids?	☐ Yes	☐ No
Does the insured adhere to the CDC's Opioid Prescribing Guidelines?	☐ Yes	☐ No
Does the insured adhere to their applicable prescription drug monitoring program, for example state specific Physician Monitoring Program (PMP)?	☐ Yes	☐ No
Has the insured been part of/named in any multidistrict litigation (MDL) or class action lawsuit?	☐ Yes	☐ No

What percentage of prescriptions filled are for opioids?

☐ Under 10% ☐ 11% to 30% ☐ 31% to 50% ☐ > 50%

2. Compounding Practices:

Does the insured compound medications in bulk, manufacture or wholesale medicine?	☐ Yes	☐ No
Are all active ingredients purchased from manufacturers that are registered with the FDA?	☐ Yes	☐ No
Does the insured provide any sterile compounding services?	☐ Yes	☐ No
Of the sterile compounding services, does the insured provide and 'High-Risk' compounds as defined by the USP Risk Level Determinations?	☐ Yes	☐ No
Is the insured registered as on outsourcing facility under section 503B under the Drug Quality and Security Act?	☐ Yes	☐ No

3. Prescription Details: (for all no answers, please elaborate in the comments/explanations section)

Are any drugs imported?	☐ Yes	☐ No
Are all drugs dispensed FDA approved?	☐ Yes	☐ No
Are all look-alike drug names stored separately and not alphabetically?	☐ Yes	☐ No
Does the insured perform age specific/pediatric dose range checks?	☐ Yes	☐ No
Are there medication administration, dispensing, and storage policies/procedures in place?	☐ Yes	☐ No
Are all drugs dispensed with current written instructions?	☐ Yes	☐ No
Does the insured provide any translation or interpreting services?	☐ Yes	☐ No

Has the insured been surveyed within the past three years by the National Association of Boards of Pharmacy (NAPB) for accreditation? ☐ Yes ☐ No

Does the insured have access to drug information to detect problematic or look-alike drug names, packaging or labeling? (i.e. Drug Facts and Comparisons, Micromedex, etc.)? ☐ Yes ☐ No

Are any drugs for any high value animals (>$25,000) or livestock? ☐ Yes ☐ No

Are telephone orders only taken by a pharmacist from authorized professional staff and repeated back to the prescriber for verification? ☐ Yes ☐ No

For telephone orders, is there a reconciliation process? ☐ Yes ☐ No

If yes: ☐ Verbal ☐ Email ☐ Written

SECTION 5: OPERATIONS

1. Certificate of operations:

Is the pharmacy a safe haven for community disposal of waste and medical equipment? ☐ Yes ☐ No

Is there a process for waste management and disposal? ☐ Yes ☐ No

2. Additional Services & Revenue (for medical equipment, please schedule the type the insured sells or leases or repairs for others in the 'COMMENTS / EXPLANATIONS' section):

Revenues	**Past 12 Months**	**Projected**
Sundries Sales (revenues)		
Medical Equipment Sales (revenues)		
Medical Equipment Rental (revenues)		
Home Services (revenues)		
Other:_____		

Patient Visits (Number)	**Past 12 Months**	**Projected**
Clinic Visits		
Immunizations Administered		
Vaccinations Administered		
In Home Visits		
Infusion Therapy Visits		
Other:_____		

3. Has the insured completed CMS Form 855S (Medicare Enrollment Application for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers)? ☐ Yes ☐ No

SECTION 6: STAFFING AND TRAINING

1. Staffing Profile (Including Employed, Contracted, and Volunteers):

Staff Type	**Number of Staff Full Time / Part Time**		**Annual Hours Worked**	**Payroll**
Pharmacists				
Pharmacy Technicians				

Registered Nurses (RN's)				
Nurse Practitioners (NPs)				
Other:_____				

2. What is the insured annual staff turnover rate?_____

3. What is the average training time provided for new hires prior to clinical work?

☐ No Training ☐ 1 – 10 Hours ☐ > 10 Hours

4. What is the average training time provided for employees and contractors annually?

☐ No Training ☐ 1 – 10 Hours ☐ > 10 Hours

5. Risk Management:

How often is a performance review of staff completed? ☐ Never ☐ Every 6 months ☐ Annually

How frequently does the insured run their employee and contractor list through the Medicare exclusion list?

☐ On Hire Only ☐ Every Month ☐ Annually ☐ Never

6. Policies and Procedures:

How frequently are the insured's policies and procedures updated? ☐ Annually ☐ As Necessary ☐ Never

SECTION 7: EMPLOYEE BENEFITS LIABILITY ☐ Not Requested

1. How frequently does the insured offer open enrollment periods?

☐ On Hire Only ☐ Semi Annually ☐ Annually

2. Open enrollment:

Does open enrollment require the insured to actively elect coverage enrollment? ☐ Yes ☐ No

Does the insured a signed acceptance or rejection of benefit programs each enrollment? ☐ Yes ☐ No

Is a physical exam required prior to enrollment in a Group Health/Life Insurance Program? ☐ Yes ☐ No

Does the insured allow for enrollment changes due to life changing events? ☐ Yes ☐ No

Does the insured use an outsourced provider to manage their benefit plans? ☐ Yes ☐ No

SECTION 8: HIRED AND NON-OWNED AUTOMOBILES ☐ Not Requested

1. Does the insured:

Annually check MVRs (motor vehicle records)? ☐ Yes ☐ No

Require all drivers to carry the state mandated personal auto liability limits? ☐ Yes ☐ No

Transport any clients? ☐ Yes ☐ No

Make any deliveries? ☐ Yes ☐ No

Confirm all drivers are at least 21 years of age? ☐ Yes ☐ No

Annual reimbursable miles driven for all personal vehicles on behalf of the company? _____miles

SECTION 9: ABUSE AND MOLESTATION ☐ Not Requested

1. Does the insured:

Have a zero tolerance policy for sexual and physical abuse? ☐ Yes ☐ No

Require all staff to undergo an abuse registry check? ☐ Yes ☐ No

Require all staff to undergo a criminal background check? ☐ Yes ☐ No

SECTION 10: GENERAL LIABILITY

Not Requested

1. Is the insured (pharmacy) located within a larger entity/facility? (if yes, please elaborate in the comments/explanations section) ☐ Yes ☐ No
2. Is there any exposure to radioactive materials? ☐ Yes ☐ No
3. Does the insured provide or are they responsible for any parking facilities? ☐ Yes ☐ No
4. Does the insured provide any services outside of the physical pharmacy itself (i.e. in home)? ☐ Yes ☐ No
5. Has the insured ever experienced any robberies, burglaries, thefts or pilferage? ☐ Yes ☐ No

SECTION 11: UNDERWRITING INFORMATION

If you answer "Yes" to any of the questions below, complete the Supplemental Claim Information Form or provide further explanation in the comments section at the end of this application.

1. Has any insurance carrier ever declined, cancelled, refused to renew, restricted, or surcharged any professional liability insurance policy issued to your organization or any owner/officer? ☐ Yes ☐ No
2. Have you, your organization or any health care professional rendering services on your behalf ever been notified of an involvement in a malpractice claim, suit, or incident, either directly or indirectly? If **Yes**, how many claims, suits or incidents have been brought to your attention? (Complete a Supplemental Claim Information Form for each) _____ ☐ Yes ☐ No
3. Have you, your organization or any health care professional rendering services on your behalf ever been investigated or audited by a governmental or regulatory agency? ☐ Yes ☐ No
4. Has any healthcare practitioner, patient, or insurance plan ever filed a complaint of any kind against you or your organization with a medical society, foundation or state/federal agency? ☐ Yes ☐ No
5. Are you or any health care professional rendering services on your organization's behalf aware of any conduct, circumstance, occurrence, incident or accident that is likely to or reasonably could be expected to give rise to a claim? ☐ Yes ☐ No
6. Have you, your organization or any health care professional rendering services on your behalf ever been notified of an involvement in an advertising injury (defamation, libel, or slander) claim, suit, or incident, either directly or indirectly? ☐ Yes ☐ No
7. Does any healthcare professional working in your organization currently have or in the past had a probationary, restricted or suspended license? ☐ Yes ☐ No
8. Do the principal owners of your organization, operate, or control any specialized, medically related business, such as a long term care facility, independent living facility, residential care facility for the elderly, adult day care center, medical transportation risk, etc. that has not been previously named and described in this application? ☐ Yes ☐ No
9. Have you, your organization or any health care professional rendering services on your behalf ever been notified of a revocation or suspension in Medicare or Medicaid reimbursement ability? ☐ Yes ☐ No

COMMENTS / EXPLANATIONS

NOTICE

To All Prospective Insureds: 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, for the purpose of misleading, conceals information concerning any fact material thereto, may commit a fraudulent insurance act which is a crime and subjects such person to criminal and civil penalties in many states.

To Prospective Insureds In:

Notice to California Applicants: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Notice to Colorado Applicants: 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 claiming with regard to a settlement or award payable for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Notice to District of Columbia and Louisiana Applicants: "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."

Notice to Florida Applicants: Any person who knowingly and with intent to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Notice to Oklahoma Applicants: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

Notice to Kansas Applicants: An act committed by 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.

Notice to Maine, Tennessee, Virginia and Washington Applications: 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 and/or denial of insurance benefits.

Notice to Maryland Applicants: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Notice to New Hampshire Applicants: Any person who, with a purpose to injure, defraud or deceive an insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud as provided in RSA 638:20.

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 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 $5,000 and the stated value of the claim for each such violation.

Notice to New York Applicants (Fire insurance applications): 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 fact material thereto, commits a fraudulent insurance act, which is a crime. The proposed insured affirms that the foregoing information is true and agrees that these applications shall constitute a part of any policy issued whether attached or not and that any willful concealment or misrepresentation of a material fact or circumstances shall be grounds to rescind the insurance policy.

Notice to New York Applicants (Automobile): Any person who knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the department of motor vehicles or an insurance company, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the value of the subject motor vehicle or stated claim for each violation."

Notice to Pennsylvania Applicants: 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 purposes 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.

Notice to Pennsylvania Applicants (Automobile): Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete or misleading information, shall, upon conviction, be subject to imprisonment for up to seven (7) years and the payment of a fine of up to $15,000.

THE UNDERSIGNED AUTHORIZED OFFICER OF THE APPLICANT DECLARES THAT THE STATEMENTS SET FORTH HEREIN ARE TRUE, AND AFFIRMS THAT IF THE INFORMATION SUPPLIED IN THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE EFFECTIVE DATE OF INSURANCE, THE UNDERSIGNED WILL IMMEDIATELY NOTIFY THE INSURER OF SUCH CHANGES, AND THE INSURER MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS OR AUTHORIZATIONS OR AGREEMENT TO BIND INSURANCE. FURTHERMORE, THE UNDERSIGNED DECLARES THAT THE SIGNING OF THIS FORM DOES NOT BIND COVERAGE NOR COMMIT TO ORDERING COVERAGE.

This application is for insurance to be placed on a surplus lines basis with Hudson Excess Insurance Company.

_____ _____

Signature **Date**

_____

Print Name/Title

Supplemental Claim Information Form

1. Full name of applicant: _____

2. Full name of claimant: _____

3. Indicate whether: ☐ Claim ☐ Suit ☐ Incident Report

4. Date of incident: _____ 5. Date claim was reported to Carrier: _____

6. Additional defendants: _____

7. If closed:
   Total loss paid including deductible: $ _____ Defense costs: $ _____

   Check One: ☐ Court judgment ☐ Out of court settlement
   Date closed: _____

8. If pending:
   Claimant's settlement demand: $ _____

   Defendant's offer for settlement: $ _____

   Insurer's loss reserve: $ _____

   Deductible amount: $ _____

   Is claim in suit? ☐ Yes ☐ No
   If **Yes**, amount asked in summons: $ _____

9. Insurance carrier:_____

10. Description: (Provide enough information to allow evaluation. Use reverse side or additional sheet if required.)

A. Alleged act, error or omission upon which Claimant bases claim:

B. Description of case and events:

C. Description of the type and extent of injury or damage allegedly sustained:

_____ _____
Signature of applicant Date