☐ **Deerfield Insurance Company**
☐ **Evanston Insurance Company**
☐ **Essex Insurance Company**
☐ **Markel American Insurance Company**
☐ **Markel Insurance Company**
☐ **Associated International Insurance Company**

APPLICATION FOR PHARMACY PROFESSIONAL LIABILITY

Notice: The policy for which application is made applies only to "Claims" first made during the "Policy Period." The limits of liability shall be reduced by "Claim Expenses" and "Claim Expenses" shall be applied against the deductible, unless the policy is amended by endorsement.

Please read the policy carefully.

If space is insufficient to answer any question fully, attach a separate sheet.

If response is none, state NONE.

I. GENERAL INFORMATION

1. (a) Full name of Applicant: _____

   (b) Principal business premise address: _____
   (Street) (County)

   _____
   (City) (State) (Zip)

   (c) (i) Phone: _____

   (ii) E-Mail Address: _____ (iii) Website Address: _____

   (d) Date formed/organized (MM/DD/YYYY): _____
   Attached a proforma business plan if the Applicant is newly formed/organized.

2. Is the Applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule? .....[ ] Yes [ ] No
   If Yes,
   (a) Has the Applicant implemented procedures to comply with the HIPAA Privacy Rule?.....[ ] Yes [ ] No
   (b) Provide the name and title of the Applicant's Privacy Officer. _____
   Our Business Associate Agreement is available at https://www.markelcorp.com/US-Insurance/HIPAA. This is the only Business Associate Agreement we will recognize.

II. OPERATIONS

1. Provide the percentage of services rendered:

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

2. Does the Applicant dispense any drugs that are:
   (a) Imported from outside the United States of America?.....[ ] Yes [ ] No
   (i) If Yes, provide details. _____

   _____
   (b) Not FDA approved, including compounded drugs?.....[ ] Yes [ ] No
   (i) If Yes, provide details. _____

3. Does the Applicant have any operations outside of the United States of America? .....[ ] Yes [ ] No
   (a) If Yes, provide details. _____

4. Are all prescriptions authorized by a licensed physician licensed in the state where prescriptions are dispensed? .....[ ] Yes [ ] No
   (a) If No, provide details. _____

5. Complete the following for each of the Applicant's locations.

Name	Address	% Ownership	Description of Operations

6. Is the Applicant in compliance with all local, state and federal laws that govern the manufacture, control, dispensing and distribution of prescription drugs? .....[ ] Yes [ ] No
   (a) If No, provide details. _____

7. (a) Number of prescriptions filled during the last twelve (12) months: _____
   (b) Number of prescriptions projected to be filled during the next twelve (12) months: _____

8. Annual Gross Receipts:

	Last 12 Months	Next 12 Months
Compounding Sales:	$_____	$_____
Prescription Sales:	$_____	$_____
Sterile Compounding Sales:	$_____	$_____
Sundries Sales:	$_____	$_____
Medical Equipment Sales:	$_____	$_____
Medical Equipment Rental:	$_____	$_____
In Home Therapy:	$_____	$_____
Other: _____	$_____	$_____
TOTAL:	$_____	$_____

III. LICENSE INFORMATION

1. Provide the following information for all states in which the Applicant operates:

State	License No.	Effective Date	Expiration Date	Active (Yes/No)

2. Federal DEA License No. and status: _____

3. Inspections:
   (a) Date of last inspection: _____/_____/_____
   (b) Name of inspecting agency: _____
   (c) Has a Deficiency Notice or a Notice of Non-Compliance ever been issued? .....[ ] Yes [ ] No
   If Yes,
      (i) What was the date of compliance? _____/_____/_____
      (ii) Attach a copy of the notice.

IV. PROFESSIONAL SERVICES

1. Does the Applicant:
   (a) Provide mail order services? .....[ ] Yes [ ] No
      (i) If Yes, provide details of safety controls used to assure a licensed physician has authorized prescriptions. _____
   (b) Provide Pharmacy Benefit Management services, including, formulary management and design, medical necessity review, credentialing review, pharmacy data and supporting services? .....[ ] Yes [ ] No
      (i) If Yes, attach a list of the Applicant's five (5) largest clients and provide a copy of a sample contract.
   (c) Compound in bulk, manufacture or wholesale drugs or products? .....[ ] Yes [ ] No
      (i) If Yes, complete Section VII. Compound Sterile Preparations.
   (d) Provide specialized pharmacy services such as nuclear or veterinarian services? [ ] Yes [ ] No
      (i) If Yes, provide details. _____

2. Does the Applicant provide services to the following:
   (a) Correctional Facility .....[ ] Yes [ ] No

(b) Hospital .....[ ] Yes [ ] No
(c) Long Term Care Facility .....[ ] Yes [ ] No
(d) If any of the above is Yes, provide a copy of a sample contract for each Yes answer.

3. Does the Applicant or any employed pharmacists provide:
(a) Flu Vaccinations .....[ ] Yes [ ] No
(b) Shingles Vaccinations.....[ ] Yes [ ] No
(c) Pneumonia Vaccinations .....[ ] Yes [ ] No
(d) Rapid HIV testing.....[ ] Yes [ ] No
(e) Counseling of Rapid HIV test subjects .....[ ] Yes [ ] No

4. Does the Applicant grow, blend or prepare for use medical marijuana and/or herbal medicinal remedies?....[ ] Yes [ ] No
If Yes, attach a completed Supplement for Medical Marijuana Dispensing.

5. Does the Applicant participate in error data reporting to Institute for Safe Medication Practices (ISMP)?.....[ ] Yes [ ] No

6. Provide the types of medical supplies and/or equipment that the Applicants sells, leases or repairs for others:

Type	Estimated Annual Receipts	
	Last 12 Months	Current 12 Months

V. STAFF

1. Total number of professional employees employed by the Applicant: _____

2. (a) Provide the number of persons employed by the Applicant for each of the following:

_____ Nurses Practitioners _____ Pharmacy Technicians

_____ Pharmacists _____ Physician Assistants

_____ Pharmacy Technicians _____ RNs

_____ Respiratory Therapists _____ Other (describe) _____

(b) Are the above individuals:
(i) All licensed in accordance with applicable state and federal regulations?.....[ ] Yes [ ] No
a. If No, provide details. _____
(ii) Any licensed or authorized in accordance with applicable state law to document medical necessity for marijuana use? .....[ ] Yes [ ] No

3. Does the Applicant supervise or contract with any individual other than its own employees? .....[ ] Yes [ ] No
If Yes,
(a) Provide an explanation of responsibilities and a description of the Applicant's relationship to the organization which employs these individuals. _____
_____
(b) Does the Applicant require all contracted staff to carry their own Professional Liability Insurance? .....[ ] Yes [ ] No
If Yes,
(i) What are the minimum limits of liability that are required? _____
(ii) Does the Applicant require Certificates of Insurance? .....[ ] Yes [ ] No

VI. RISK MANAGEMENT

1. Are telephone orders only taken by a pharmacist from authorized professional staff and repeated back to the prescriber for verification?.....[ ] Yes [ ] No
2. (a) Are products with known look-alike drug names stored separately and not alphabetically?.....[ ] Yes [ ] No
(b) Are special alerts built into the system concerning problematic or look-alike drug names, packaging or labeling?.....[ ] Yes [ ] No

(c) What safety controls are in place to address problematic or look-alike drug names, packaging or labeling?

3. Does the Applicant have access to drug information (i.e., Drug Facts and Comparisons, Micromedex, etc.)? .....[ ] Yes [ ] No
4. Does the Applicant perform pediatric dose range checks? .....[ ] Yes [ ] No
5. How does the Applicant detect drug contraindications, interactions, duplications against medical history and other prescribed drugs?
6. What criteria are established (i.e. targeted high-alert drugs, patient population) to trigger required medication counseling (i.e. alert tag)?
7. Are all prescriptions dispensed with current written instructions? .....[ ] Yes [ ] No
8. Does the Applicant accept electronic prescriptions? .....[ ] Yes [ ] No
   If Yes,
   (a) What safety controls are in place to assure prescriptions are prescribed by a licensed physician?
9. How is drug waste and expired drugs disposed?

VII. COMPOUNDING STERILE PREPARATIONS

1. Does the Applicant dispense Compounded Sterile Preparations to any states or jurisdiction outside the location(s) provided in Question II. 5? .....[ ] Yes [ ] No
   If Yes, list all other states and jurisdictions.
2. Is the Applicant registered as an outsourcing facility with the Food and Drug Administration (FDA)?.....[ ] Yes [ ] No
3. Indicate USP categories of Compounded Sterile Preparations that all locations to be covered prepare. Check all that apply.

   ____ Immediate-Use Risk Level ___ Low Risk Level ___ Medium Risk Level ___ High Risk Level

4. Indicate the percent of revenues from Compounded Sterile Preparations prepared by the Applicant.

Cardioplegia Solutions	___%	Irrigating Solutions	___%
Chemotherapy	___%	Ophthalmic Solutions	___%
Corticosteroid Suspensions	___%	Serums, toxins, vaccines	___%
Enteral Feedings	___%	TPN	___%
HRT	___%	Veterinary Preparations	___%
IVs	___%	Other (describe) _____	
		_____	___%

5. Indicate the number of prescriptions for Compounded Sterile Preparations (CSPs) that all locations to be covered dispense on an annualized basis:

   _____ 1 to 25 CSPs ____ 101 to 250 CSPs
   _____ 26 to 100 CSPs ____ over 250 CSPs

VIII. CLAIMS/HISTORY

1. Has the Applicant or any principal, partner, owner, officer, director, employee, manager or managing member of the Applicant or any person(s) or organization(s) proposed for this insurance or any predecessor, subsidiary or affiliated organization ever:
   (a) Been the subject of disciplinary or investigatory proceedings or reprimand by a licensing, administrative or governmental agency? .....[ ] Yes [ ] No
      (i) If Yes, provide details.
   (b) Been convicted for an act committed in violation of any law or ordinance including traffic offenses? .....[ ] Yes [ ] No
      (i) If Yes, provide details.
   (c) Been evaluated or treated for alcoholism or drug addiction or mental or emotional disorders? .....[ ] Yes [ ] No
      (i) If Yes, provide details.

(d) Had any professional license or license to prescribe or dispense narcotics denied, limited, refused, suspended, revoked, renewal refused or accepted only on special terms or voluntarily surrendered any professional license? .....[ ] Yes [ ] No
(i) If Yes, provide details. _____

2. Has any claim or suit for malpractice ever been made against the Applicant, or any principal, partner, owner, officer, director, employee, volunteer worker, manager or managing member of the Applicant or any person(s) or organization(s) proposed for this insurance or any predecessor, subsidiary or affiliated organization? .....[ ] Yes [ ] No
(a) If Yes, how many?_____
(b) If Yes, provide five (5) years of currently valued Professional Liability Insurance claim runs from current and prior insurers or complete a Supplemental Claim Information form (SM6236) for each claim..

3. Is the Applicant and/or any principal, partner, owner, officer, director, employee, manager or managing member thereof or any person(s) or organization(s) proposed for this insurance aware of any act, error, omission, fact, circumstance, situation, incident or allegation of negligence or wrongdoing, or records request from any attorney which may result in a malpractice claim or suit? .....[ ] Yes [ ] No
(a) If Yes, provide details. _____

4. Has any application for similar insurance made on behalf of the Applicant and/or any principal, partner, owner, officer, director, employee, manager or managing member thereof or any predecessor, subsidiary or affiliated organization thereof ever been declined, cancelled or nonrenewed? .....[ ] Yes [ ] No
(a) If Yes, provide details. _____

5. List prior Professional Liability Insurance for each of the last five (5) years, including the current year:
If None, check here. [ ]

Ins Company	Limits of Liability	Premium	Eff./Exp. Dates	Claims Made or Occurrence Form	Retroactive Date

IX. GENERAL LIABILITY (To be completed by the Applicant if applying for General Liability.)

1. Complete the following for each of the Applicant's facilities to be covered:

Location Number	Name of Facility	Address of Facility	Description (Yes/No)	Does the Applicant Maintain a Garage? (Yes/No)	Is There an Adjacent Exposure?
1					
2					
3					
4					

2. Complete the following for each of the Applicant's locations:

	Location 1	Location 2	Location 3	Location 4
Square Footage*				
Year Built				
Year Remodeled				
Number of Stories				
Type of Construction (frame, brick, concrete)				
Percentage of Building Occupied by Applicant				
Other occupants? (Yes/No)				

*Include square footage of parking facilities if owned or rented by the Applicant.

3. Are all of the Applicant's locations equipped with:
(a) Complete Sprinkler System?.....[ ] Yes [ ] No

(b) At least two clearly marked exits on each floor? .....[ ] Yes [ ] No
(c) Smoke detectors?.....[ ] Yes [ ] No
(d) Emergency electrical system? [ ] Yes [ ] No
(e) Heat sensors? [ ] Yes [ ] No
(f) Fire escape(s)? [ ] Yes [ ] No
(g) Posted emergency evacuation procedures? [ ] Yes [ ] No
(h) Properly maintained fire extinguishers? [ ] Yes [ ] No

If any of the above are answered No, provide details by attachment.

4. Does the Applicant have a written safety program in place? .....[ ] Yes [ ] No
   If Yes, attach a copy of the written safety program.
5. Does the Applicant have written procedures for incident reporting? .....[ ] Yes [ ] No
6. Do any of the Applicant's locations have any:
   (a) Exposure to flammables, explosive, chemicals? [ ] Yes [ ] No
   (b) Catastrophe exposure? ....[ ] Yes [ ] No
   (c) Exposure to radioactive materials? .....[ ] Yes [ ] No
7. Do any of the Applicant's operations involve storing, treating, discharging, applying, disposing, or transporting hazardous materials? .....[ ] Yes [ ] No
8. Does the Applicant:
   (a) Own any elevators or escalators? .....[ ] Yes [ ] No
   (b) Own or rent any parking facility? .....[ ] Yes [ ] No
   (c) Provide any recreational facility?.....[ ] Yes [ ] No
   (d) Sponsor any sporting or social events?.....[ ] Yes [ ] No

   If Yes to (a)-(d), provide details by attachment.
9. List prior General Liability Insurance for each of the last five (5) years, including the current year:

Ins Company	Limits of Liability	Premium	Eff./Exp. Dates	Claims Made or Occurrence Form	Retroactive Date

10. Has any claim for General Liability ever been made against any person(s) or entity(ies) proposed for this insurance? .....[ ] Yes [ ] No
    (a) If Yes, provide currently values loss history for claims for a minimum of the last five (5) years.
11. Is (are) any person(s) or organization(s) proposed for this insurance aware of any fact, circumstance, situation or incident which may result in a General Liability claim, such as would fall under the proposed insurance? .....[ ] Yes [ ] No
    (a) If Yes, provide details for each.

NOTICE TO THE APPLICANT - PLEASE READ CAREFULLY

No fact, circumstance, situation or incident indicating the probability of a "Claim" or action for which coverage may be afforded by the proposed insurance is now known by any person(s) or organization(s) proposed for this insurance other than that which is disclosed in this application. It is agreed by all concerned that if there be knowledge of any such fact, circumstance, situation or incident any "Claim" subsequently emanating therefrom shall be excluded from coverage under the proposed insurance.

This application, information submitted with this application and all previous applications related hereto and material changes to any of the foregoing of which the underwriting manager, Company and/or affiliates thereof receives notice is on file with the underwriting manager, Company and/or affiliates thereof and is considered physically attached to and part of the of the policy if issued. The underwriting manager, Company and/or affiliates thereof will have relied upon this application and all such attachments in issuing the policy.

For the purpose of this application, the undersigned authorized agent of the person(s) and organization(s) proposed for this insurance declares that to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this application and in any attachments, are true and complete. The underwriting manager, Company and/or affiliates thereof are authorized to make any inquiry in connection with this application. Signing this application does not bind the Company to provide or the Applicant to purchase the insurance.

If the information in this application or any attachment materially changes between the date this application is signed and the effective date of the policy, the Applicant will promptly notify the underwriting manager, Company and/or affiliates thereof, who may modify or withdraw any outstanding quotation or agreement to bind coverage.

The undersigned declares that the person(s) and organization(s) proposed for this insurance understand that the liability coverage(s) for which this application is made apply(ies):

(i) Only to “Claims” first made during the “Policy Period;

(ii) Unless amended by endorsement, the limits of liability contained in the policy shall be reduced, and may be completely exhausted by “Claim Expenses” and, in such event, the Company will not be liable for “Claim Expenses” or the amount of any judgment or settlement to the extent that such costs exceed the limits of liability in the policy; and

(iii) Unless amended by endorsement, “Claim Expenses” shall be applied against the “Deductible”.

WARRANTY

I/We warrant to the Company, that I/We 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 and deemed incorporated therein, should the Company evidence its acceptance of this application by issuance of a policy. I authorize the release of claim information from any prior insurer to the underwriting manager, Company and/or affiliates thereof.

Must be signed within 60 days of the proposed effective date.

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

Notice to 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 subjects the person to criminal and civil penalties.