*Member Companies of Western World Insurance Group*

☐ Western World Insurance Company

☐ Tudor Insurance Company

# Supplemental Application For
# Drug Stores & Druggist Liability
## (Complete in addition to ACORD)

1. Name of Applicant: ______________________

   Applicant's Web Site Address: ______________________

2. Provide full name(s) of individual and partners. ______________________

   ______________________

3. What state/s are you licensed or certified in? Provide details of what your license/certification allows you to do.

   ______________________

   ______________________

4. Does applicant's license allow the prescribing of drugs or other medications? Yes No

5. Has applicant's license to prescribe or dispense narcotics ever been suspended, revoked, had renewal refused or was ever suspended voluntarily? Yes No

6. Has applicant ever been investigated by the State Health Dept., State Licensing Board or other governmental body or administrative agency or professional association? Yes No

   *If yes to either question above, provide full details on Attachment to A101.*

7. Is pharmacy in compliance with all local, state and federal laws and regulations that govern the manufacture, control, dispensing and distribution of prescription drugs? Yes No

8. Annual number of Prescriptions filled? ______________________

   Are all dispensed drugs FDA approved? Yes No

9. Describe nature of operations including types and percentages:

   Retail ______________________

   Wholesale ______________________

   Mail Order ______________________

   Drug Benefit ______________________

   Compounding ______________________

   Other ______________________

   Explain: ______________________

10. Annual Gross Sales: ______________________

    From Prescription Sales ______________________

    From Non-Prescription Sales ______________________

    From Medical Equipment Sales ______________________

    From Medical Equipment Rental ______________________

    From Physical or Respiratory Therapy ______________________

    Other ______________________

    Explain: ______________________

11. Do employed pharmacists have their own Professional Liability coverage? ☐ Yes ☐ No

    Limits Required? $ ______________________

    Does the applicant require Certificates of Insurance from all contracted pharmacists? ☐ Yes ☐ No

    Limits Required? $ ______________________

12. Applicant's premium is adjustable based on **gross sales**. *Our auditor will verify applicant's gross sales.*

    If this information is kept by the applicant's accountant, please provide accountant's name, address and telephone number.

    ______________________

    If this information is kept by the applicant, please provide the telephone number and address where the records are kept.

    ______________________

    If you are not normally at this location during working hours, please provide a beeper number or telephone number where you can be reached: ______________________

    Applicant's telephone number if not previously given: ______________________

13. Prior coverage:

| Insurance Company | Year | Premium | Type? Occurrence/ Claims Made* | Any Claims (Check One) | Description |
|---|---|---|---|---|---|
| | | | ☐ Occ ☐ CM | ☐ Yes ☐ No | |
| | | | ☐ Occ ☐ CM | ☐ Yes ☐ No | |
| | | | ☐ Occ ☐ CM | ☐ Yes ☐ No | |
| | | | ☐ Occ ☐ CM | ☐ Yes ☐ No | |
| | | | ☐ Occ ☐ CM | ☐ Yes ☐ No | |

* If Claims Made, what is retro date? ____________________

14. Is the applicant aware of any circumstances which may result in a claim? ☐ Yes ☐ No
    *If yes, provide full details on Attachment to A101.*

15. Does the applicant want the policy to cover employees? ☐ Yes ☐ No
    (Note: The policy already protects the applicant for the acts of his/her employees.)

16. Does a licensed physician in State where services are rendered issue all prescriptions? ☐ Yes ☐ No

17. Is applicant a "Covered Entity" under HIPPA Privacy Rule? ☐ Yes ☐ No
    If yes, has applicant implemented procedures to comply with HIPPA Privacy Rule? ☐ Yes ☐ No

18. Does applicant provide mail order services? ☐ Yes ☐ No
    If yes, how does applicant assure a licensed physician authorizes prescriptions? ____________________

19. Does applicant provide any Pharmacy Benefit Management Services such as drug utilization review, medical necessity review, etc? ☐ Yes ☐ No

20. Does applicant provide specialized pharmacy services such as nuclear, chemotherapy infusions or other? ☐ Yes ☐ No
    If yes, please provide details. ____________________

21. Please provide details of employed or contracted personnel:

| | Number Employed | Number Contracted | Contractors Ins. Limits Required |
|---|---|---|---|
| Pharmacists | | | |
| Pharmacy Technicians | | | |
| RN's | | | |
| LPNs | | | |
| Physicians | | | |
| Therapists | | | |
| Others (Specify) | | | |

22. **Limits of Insurance Requested**

| | | |
|---|---|---|
| General Aggregate Limit (Other than Products-Completed Operations) | $ | |
| Products-Completed Operations Aggregate Limit | $ | |
| Personal and Advertising Injury Limit | $ | |
| Each Occurrence Limit | $ | |
| Damage to Premises Rented to You (Up to $100,000 limit available) | $ | Any One (1) Premises |
| Medical Expense Limit (Up to $5,000 limit available) | $ | Any One (1) Person |
| Each Professional Incident Limit (if applicable) | $ | |

23. Effective Dates Desired – From: ____________________ To: ____________________

Applicant's Signature ____________________ Date ____________________

Title ____________________ Producing Agent ____________________

Name of Applicant ______________________________

| # | Description or Full Details |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |