HISCOX PRO™

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. Email address:

6. Website:

7. 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

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

Retail	%	Wholesale	%	Non-sterile compounding	%
Vaccination	%	Sterile Compounding	%	Mail order	%
Physician dispenser	%	Veterinary	%	Pharmacy benefits management	%
Infusion	%	Radiopharmacy	%		

Other – please describe: %

9. If compounding any sterile preparations, please describe the types of sterile compounds prepared. N/A ☐

10. Annual number of prescriptions filled:

Last 12 months: Next 12 months:

11. 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:	$	$

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

13. 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.

14. Does the applicant compound in bulk, batches or act as a Registered Outsourcing facility? Yes ☐ No ☐

15. 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.

Staffing information

16. 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).

General risk management procedures

17. Are any drugs imported? Yes ☐ No ☐

18. Are all the drugs dispensed FDA approved and/or all compounds prepared from FDA approved ingredients?? Yes ☐ No ☐

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

20. Do you verify all questionable orders with a phone call to the prescribing physician? Yes ☐ No ☐

21. Do you separate look alike and sound alike drugs? Yes ☐ No ☐

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

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

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

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

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

27. Are you accredited in the area of Pharmacy? Yes ☐ No ☐

If Yes, provide accreditation entity:

28. Is an informed patient consent document required for all vaccination services? Yes ☐ No ☐ None performed ☐

29. Do you verify medical history to evaluate drug interactions, contraindications and duplications? Yes ☐ No ☐

Compounding risk management procedures

30. Will you be performing compounding services? Yes ☐ No ☐

If No, please skip this section.

31. Do you follow cleaning frequency protocol as required by USP chapter 797? Yes ☐ No ☐ No Sterile Compounding ☐

32. Do you compound any drugs in advance of receiving prescriptions? Yes ☐ No ☐

If Yes, why?

33. Do you compound drugs that are copies of commercially available drug products? Yes ☐ No ☐

If Yes, why?

34. Do you compound drug products that have been removed from the market due to safety or efficacy issues? Yes ☐ No ☐

If Yes, why?

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Insurance and claims history

35. Has any similar insurance ever been declined or cancelled? Yes ☐ No ☐
If Yes, please explain in the comments section.

36. 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).

37. 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.

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

39. 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? ☐

40. 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? ☐

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Comments section

Execution

APPLICATION DISCLOSURES:

If there is any material change in the answers to the questions in this Application before the proposed policy inception date, you must notify us in writing and any outstanding quote for insurance coverage may be modified or withdrawn.

Your submission of this Application does not obligate us to issue, or you to purchase, a policy. You authorize us to make any inquiry in connection with this Application.

All written statements and materials furnished to us in conjunction with this Application are incorporated into this Application and made a part of it.

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 fact, commits a fraudulent insurance act, which is a crime.

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 ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

Declaration

I declare that (a) this application form has been completed after reasonable inquiry, including but not limited to all necessary inquiries of my fellow principals, partners, officers, directors, and employees, to enable me to answer the questions accurately and (b) its contents are true and accurate and not misleading.

I will undertake to inform you before the inception of any policy issued pursuant to this application of any material change to the information already provided or any new fact or matter that may be material to the consideration of this application for insurance.

I agree that this application form and all other information which is provided are incorporated into and form the basis of any contract of insurance.

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.