



How to apply: Simply complete the application, enclose your premium check made payable to Marsh and mail to the address provided. All coverages elected must be under the same plan limits. All premiums are annual. Coverage is effective the date your application is approved and payment is received. Please allow three to four weeks for delivery of your Policy. Please print neatly or type all information.

1. APPLICANT

ALL APPLICANTS MUST COMPLETE

Form fields for applicant information: LAST NAME, FIRST NAME, INITIAL, BUSINESS/CORPORATE NAME/DBA, NAMES OF OWNERS, PARTNERS AND CORPORATE OFFICERS WHO ARE ACTIVE IN THE BUSINESS AND THEIR PROFESSIONAL OCCUPATIONS, ADDRESS, DATE OF BIRTH, DAYTIME PHONE, CITY, STATE, ZIP, FAX NUMBER, EMAIL ADDRESS, STUDENTS ONLY—FULL NAME OF SCHOOL, SCHEDULED GRADUATION DATE, STUDENTS ONLY—ADDRESS OF SCHOOL, CITY, STATE, ZIP

2. EMPLOYED INDIVIDUALS

Annual Limits and Premiums

\$2,000,000 per incident/occurrence \$1,000,000 per incident/occurrence
\$4,000,000 annual aggregate \$3,000,000 annual aggregate

Professional Liability—Named Insured

No products liability coverage is provided.

Employed

First-Year Graduate Rate

Date of graduation

Pharmacy Technician

Premium

\$130

\$ 65

\$104

Premium

\$111

\$ 56

\$ 89

Individual Employed Coverage is not available if you have employees or independent contractors working on your behalf.

3. SELF-EMPLOYED PHARMACIST OR CONSULTANT PHARMACIST

If you own the business, or have employees or independent contractors, please complete this section.

Annual Limits and Premiums

\$2,000,000 per incident/occurrence \$1,000,000 per incident/occurrence
\$4,000,000 annual aggregate \$3,000,000 annual aggregate

Professional Liability—Named Insured

A premium must be paid for each owner active in the business.

No products liability coverage is provided.

You must pay a premium for each owner active in the business.

Self-Employed (more than 20 hours per week)

Self-Employed (20 hours or less per week)

Self-Employed First-Year Graduate Rate

OTHER (Please specify & contact administrator for premium.)

Premium

() x \$364 = \$

() x \$183 = \$

() x \$182 = \$

() x \$ = \$

Premium

() x \$311 = \$

() x \$156 = \$

() x \$156 = \$

() x \$ = \$

A premium must be paid for each professional employee active in the business.

Pharmacist employee

Pharmacist Technician employee

OTHER (Please specify & contact administrator for premium.)

() x \$130 = \$ () x \$111 = \$

() x \$104 = \$ () x \$ 89 = \$

() x \$ = \$ () x \$ = \$

SUBTOTAL Section 3

\$

\$

Indicate which of the following describes your practice and answer the questions, which follow the description.

Self-Employed Pharmacist or Consulting Pharmacist (Must Answer)

1. Do you employ other professionals? YES NO (If "YES," a premium must be paid for all employees.)

2. Do you have partners, shareholders or other owners working with you in your business? YES NO (If "YES," a premium must be paid for all owners, partners or corporate members active in the business.)

3. Do you own a pharmacy? YES NO (If "YES," include a copy of your General Liability Declarations Page)

ALL APPLICANTS MUST COMPLETE & SIGN PAGE 2 OF THIS APPLICATION

4. OPTIONAL COVERAGES (SELF-EMPLOYED INDIVIDUALS AND BUSINESS APPLICANTS ONLY)

Professional Liability—Additional Insured

(This optional coverage protects each facility under contract with the insured against claims arising out of the sole negligence of the insured. It should only be purchased if required by contract.)

Premium is for each facility under contract. () x \$193 = \$ _____ () x \$165 = \$ _____

(List name and address of each facility on a sheet of letterhead.)

General Liability

(Locations must be owned or rented by the named insured)

Do you currently carry General Liability Insurance? Yes No

If not, and you would like to purchase the optional coverage, please provide the following information:

Type of pharmacy _____

*Please note large retail chains or mail order pharmacies are not eligible to purchase General Liability coverage.

Coverage for 1st location \$140 \$120
 Each additional location () x \$59 = \$ _____ () x \$50 = \$ _____

List name and physical street address of each facility on a separate sheet of your letterhead.

5. PREMIUM CREDITS (CALCULATE YOUR PREMIUM)

Multiple Insureds Premium Credit: This credit is based upon the size of the group at the time coverage is purchased. Credits apply as follows: groups of 2–9 professionals = 4%, groups of 10–14 professionals = 8%, groups of 15 or more professionals = 12%.

| | |
|--|----------|
| Subtotal Premium (Section 2 or 3) | \$ _____ |
| Plus Optional Coverages (Section 4, if applicable) | + _____ |
| Total Premium | \$ _____ |
| Less Size-of-Group Premium Credit (if applicable) | - _____ |
| Total Premium Due (rounded to the nearest whole dollar) | \$ _____ |

6. ALL APPLICANTS MUST ANSWER UNDERWRITING QUESTIONS

1) Have you or any of your employees ever had any of the following: revoked, suspended, refused, denied renewal, placed on probation, cancelled or voluntarily surrendered by you or any of your employees or is such an action pending? (If "Yes," explain on a separate sheet of letterhead including dates and allegations.)

State License or Certification Yes No
 Malpractice Insurance** Yes No

**Notice to Missouri Residents: This question does not apply.

2) Has any claim or suit ever been brought against you or any of your employees, or are you or any of your employees aware of any incident that might reasonably lead to a claim or suit? (If "Yes," explain on a separate sheet of letterhead including dates, allegations and amounts.) Yes No

I understand that I am not covered by this insurance for rendering or failure to render any professional services as the following: physician, surgeon, dentist, nurse midwife, nurse anesthetist, perfusionist, cytotechnologist, chiropractor, podiatrist, osteopath or psychiatrist. I understand that these professional occupations are excluded from coverage. I understand that this insurance will not apply to any partner, principal or owner of a residential/overnight facility.

In order to enhance the stability of this professional liability insurance program, coverage has been organized through a purchasing group, pursuant to legislation, known as the Federal Liability Risk Retention Act of 1986, enacted by Congress. Coverage is provided to the purchasing group by Liberty Insurance Underwriters Inc. Once the completed application has been approved and the premium has been received, you will automatically become a member of the AHCPGA Purchasing Group Association, located and domiciled in Illinois and obtain the insurance coverage afforded through the Group Policy on an annual term.

This application is subject to the underwriter's approval. Your completion of this application and premium payment does not bind coverage or obligate the insurance company to issue you insurance coverage. Coverage will become effective following the receipt of your acceptable application and premium payment. Your application cannot be processed unless it is completed in its entirety. The application is subject to the company's underwriting rules.

The undersigned, on behalf of all prospective insureds, after a reasonable inquiry, declares to the best of his/her knowledge and belief that the statements contained herein are true and are the basis of the acceptance of the risk or the hazard assumed by the Company under this Policy. It is further agreed by the undersigned, its Subsidiaries and their directors, officers and trustees, that the Policy, if issued, is in reliance upon the truth of such representations. It is agreed that, although the signing of the Application does not commit the undersigned to purchase the insurance being applied for, the statements made in this Application shall become the basis of the Policy should one be purchased. The Company is hereby authorized to make any investigation and inquiry in connection with this Application deemed necessary.

(ALL STATES EXCEPT AR, CO, DC, FL, HI, KS, KY, LA, ME, MD, NJ, NM, NY, OH, OK, PA, TN, VA, WA, WV): 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.

YOU MUST SIGN AND DATE THIS APPLICATION

Signature **X** _____ Date _____

Enclosed is my check for \$ _____ Effective Date Desired* _____

*May not be earlier than the date the administrator receives and approves this application.

Make check payable to Marsh and return with this application in the business reply envelope provided.

I authorize Seabury & Smith/Marsh to charge my: VISA MasterCard

Credit Card Number _____ Expiration Date _____

Amount \$ _____ Print name exactly as it appears on card _____

Marsh/Seabury & Smith Insurance Program Management
 Roy S. Lyons, Licensed Agent
 777 S. Figueroa St., Suite 2200
 Los Angeles, CA 90017
 1-888-926-CPhA
 www.marshaffinity.com
 CA Ins. Lic. #0633005
 AR Ins. Lic. #245544
 d/b/a in CA Seabury & Smith Insurance Program Management



Underwritten by: Liberty Insurance Underwriters Inc.,
 a Member company of Liberty Mutual Group
 55 Water Street, New York, New York 10041
 May not be available in all states.
 Pending underwriter approval.

NOTE: This is only a summary of the Insurance Policy provisions. If any conflict exists with the actual Insurance Policy, the terms of the Insurance Policy control.

How to apply: Simply complete the application **AND THIS SUPPLEMENTAL APPLICATION**, enclose your premium check made payable to Marsh and mail to the address provided. All coverages elected must be under the same plan limits. All premiums are annual. Coverage is effective the date your application is approved and payment is received. Please allow three to four weeks for delivery of your Policy. **Please print neatly or type all information.**

APPLICANT

ALL APPLICANTS MUST COMPLETE

Member Nonmember

NAME _____

Business Type: Individual Corporation Partnership Joint Venture Other _____

For Students Only

Annual Limits and Premiums

If you are a student, please complete this information: \$2,000,000 per incident/occurrence \$1,000,000 per incident/occurrence
\$4,000,000 annual aggregate \$3,000,000 annual aggregate

Pharmacy Student Rate \$53 \$45

Enclosed is my check for \$ _____ Effective Date Desired* _____

*May not be earlier than the date the administrator receives and approves this application.

I authorize Seabury & Smith/Marsh to charge my: VISA MasterCard Amount \$ _____

Credit Card Number _____ Expiration Date _____

Print name exactly how it appears on card _____

Make check payable to Marsh and return with the application and this Supplemental Application, to the address shown below.

YOU MUST SIGN AND DATE THIS APPLICATION

Signature **X** _____

Date **X** _____

ALL APPLICANTS MUST COMPLETE AND SIGN THIS SUPPLEMENT

About Our Role and Compensation

The California Pharmacists Association has selected Liberty Insurance Underwriters Inc. (“Insurer”) for this insurance program. Comparable insurance products may be available in the insurance marketplace. Marsh/Seabury & Smith Insurance Program Management is only offering CPhA’s selected insurer quote proposal. In accordance with industry custom, we are compensated through commissions that are calculated as a percentage of the insurance premiums charged by insurers. We may also receive additional monetary and nonmonetary compensation from insurers, or from other insurance intermediaries, which may be contingent upon volume, profitability or other factors. This compensation may include payment from insurers for marketing-related expenses or investments in technology. Our compensation may vary depending on the type of insurance purchased and the insurer selected. We will provide you additional information about our compensation and information about alternative quotes, upon your request. You may obtain this information by referring to <https://www.personal-plans.com/disclosure> and entering the security code o3975181 or call us at 1-888-206-5088 for specific details.



Attn: Association Department

777 South Figueroa Street, Los Angeles, CA 90017

888-926-CPhA • www.MarshAffinity.com • CPhA.Insurance@marsh.com

d/b/a in CA Seabury & Smith Insurance Program Management

CA Ins. Lic. #0633005

AR Ins. Lic. #245544

Underwritten by:

Liberty Insurance Underwriters Inc.,

a Member of Liberty Mutual Group.

55 Water Street

New York, New York 10041

May not be available in all states. Pending underwriter approval.

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