



California Pharmacists Association Business Owners Package Program Application

MARSH

Sub-Producer Name: _____

Proposed effective date: _____

Address: _____

Quote Issue

City, State, Zip: _____

Premiums payable: Annually Semi-Annually Quarterly

SECTION I: General Information

Applicant's Name: _____ CPhA Member Non-Member

Pharmacist in Charge (if different from applicant): _____ CPhA Member Non-Member

Store Name: _____

Address: _____

City: _____ County: _____ Zip: _____

Phone: (_____) _____ e-mail: _____

Individual Corporation Partnership Other(describe) _____

Tax I.D.#: _____

Community Pharmacy Closed Door Pharmacy – Type: _____

- How many years has the applicant been in business? _____ years (If less than 3 years, provide details of previous experience in remarks section on page 5).
- Has the Pharmacist-in-Charge completed a self-assessment form as required by the California State Board of Pharmacy? No Yes
If Yes, date last self-assessment was completed: ____/____/____ If No, please explain in remarks section (page 5)
- Is applicant a parent or subsidiary of another entity? If Yes, provide details in remarks section (page 5). No Yes
- Are there any premises owned, occupied or controlled by applicant or are there business operations conducted by applicant other than those of a retail pharmacy? If Yes, provide details (page 5) No Yes
- Does applicant participate in filling prescriptions via the internet? No Yes
- Has any insurance company declined, cancelled or non-renewed coverage for this or similar coverage?
If Yes, provide details (page 5) No Yes
- Previous Insurance Carriers (last 3 years) Date of Loss Amount of Loss Description of Loss

WARRANTY STATEMENTS:

- Within the last five years, have any of the following ever been revoked, suspended, refused, cancelled or voluntarily surrendered?
 - State license or certification Yes No
 - Malpractice insurance Yes No
- Within the last five years, has any claim or suit for alleged malpractice ever been brought against you or are you aware of any incident that might reasonably lead to such a claim or suit?
 - Any employee Yes No
- Have you ever been convicted (as an adult) of a misdemeanor or felony or is any such case pending? Yes No
- Within the past five years, have any complaints or charges been brought against you by any licensing board or professional ethics body for violations of ethics codes, unprofessional conduct, intentional misconduct or incompetence? Yes No

Important: If the answer to any of the above questions is "Yes", please attach a written explanation on a separate sheet of paper.

SECTION I: General Information (Continued)

OPERATIONS: Gross Receipts: \$ _____

(Combined total of all items marked must equal 100%)

_____ % Prescription Drugs	_____ % Sterile Compounding
_____ % Non-Prescription Drugs	_____ % Non-Sterile Compounding
_____ % Sale of DME	_____ % Cosmetics
_____ % Rental of DME	_____ % Food & beverage (no alcohol)
_____ % Repair of DME	_____ % Alcoholic Beverages
_____ % IV Solutions	_____ % Other _____
_____ % Nursing	_____ % Other _____

Average number of scripts filled daily: _____

Business Hours: Monday – Friday _____ Saturday _____ Sunday _____

SECTION II: Property Information

Location #: 1

Number of years at this location: _____ Applicant is: Tenant Lessor Owner-Occupant

Address (If different than on page 1): _____

Construction:* Frame Joisted Masonry Masonry Noncombustible Noncombustible Fire Resistive
 Sprinklered Non-Sprinklered

Age of Building: _____ years If age exceeds 20 years, indicate year when the following were significantly upgraded by a qualified contractor: _____ Plumbing Systems _____ Heating Systems
_____ Electrical Systems _____ Roofing

Number of stories: _____ Protection grade: _____

Fire Hydrant distance: Less than 100 ft? Less than 500 ft.?

Any graffiti on building or adjacent building? Yes No

Crime Area: Low Medium High

Any cooking exposures within/adjacent to the property? No Yes (Explain in remarks section)

Coverage Elections: (Earthquake coverage not included)

Building and Business Personal Property: The amount of insurance given must be 90% or higher of property values.

Building: Limit of Insurance \$ _____ Deductible: \$250 \$500 \$1,000 \$2,500
Area of building: _____ sq. ft. (Max: 15,000)
Occupy **LESS** than 75% Occupy **MORE** than 75%

Business Personal Property: (Including tenants improvements & betterments)

Limit of Insurance \$ _____ Deductible: \$500 \$1,000 \$2,500
Area of Occupancy: _____ sq. ft. (Max: 15,000) Floor of Occupancy: _____

* Construction Definitions:
Frame – Wood or mostly wood construction
Joisted Masonry – Brick, block, concrete load bearing walls.
Roof and floor supports are wood.
Non-Combustible – Metal structural wall and roof supports,
NO wood roof decking or wood siding.

Masonry Non-Combustible – Masonry load bearing walls and unprotected steel roof supports.
Fire Resistive – Masonry or protected steel load bearing walls and roof supports. (Steel is protected by encasing it in concrete or spraying on fire resistive insulation.)

SECTION II: Property Information (Continued)

Minimum coverages automatically included: (Indicate if additional coverage is required)

Loss of Income: Automatically included. Business interruption/extra expense
Maximum of 12 consecutive months to actual loss sustained

Electronic Data Processing: Minimum included or \$ _____
Equipment, media & data

Accounts Receivable: Minimum included or \$ _____

Valuable Papers: Minimum included or \$ _____

Money & Securities: Minimum included or \$ _____ / \$ _____ (Max. \$20/\$20)
Safe: None Fire Resistive Burglar Resistive Burglar Proof

Employee Dishonesty: Minimum included or \$ _____ (Maximum \$100,000)
Checks counter signed?: No Yes All or Over \$ _____
Audit frequency: Annual Quarterly

Glass Coverage: Included (subject to a \$250 deductible)

Exterior Signs: Included (subject to a \$250 deductible)

PROPERTY Questionnaire

Burglar Alarm/Protection:

None Local Central Hold up button Motion, Infrared or Laser Sensors Tamper proof line
 Night Watchman Local police patrols

Doors: Double cylinder dead bolt locks

Windows/ skylights: Gratings, bars, grills

Security lights on when premises closed

Well traveled thoroughfare

Premises inspected and cleaned 3 times/week

Fire extinguishers: 2 or more displayed and charged

"No Smoking" signs posted/enforced in storage areas

Overnight trash stored in approved fire containers

Paved surfaces kept free of debris, oil, snow etc.

Supply area neat and free of flammables

Options: EQ (not available in CA) EQSL: \$ _____ Limit

SECTION III: Liability Information

Business Liability: \$2,000,000 per occurrence – Included BI/PD CSL Umbrella Limit: \$ _____
\$2,000,000 products/completed operations MultiCover Endorsement
\$4,000,000 general aggregate Business Owners Extension Endorsement
\$10,000 per occurrence – Medical payments

Tenant's Legal Liability: Minimum included or \$ _____

Hired and Non-Owned Auto: Include Exclude **(Not eligible if Business Autos are covered elsewhere.)**

LIABILITY Questionnaire – General

Are all prescriptions checked by at least 2 qualified persons prior to sale? No* Yes

Are the identities of all customers and their prescriptions checked prior to sale? No* Yes

Are all the appropriate warnings prominently displayed on containers and explained to patients? No* Yes

* Provide details in remarks section on page 5

SECTION III: Liability Information (Continued)

LIABILITY Questionnaire – Continued

- Do employed pharmacists have their own professional liability insurance? No Yes N/A
- Are independently contracted pharmacists utilized? No Yes
If yes, are they required to carry their own professional liability insurance? No Yes
- Are business-owned vehicles used by employees for business related activities? No Yes
If yes, do you have a vehicle maintenance program? No Yes
- Do employees drive personal vehicles for business-related activities? No Yes
If yes, number of days per week: . . . Daily . . . 1–2 Days . . . 2–3 Days . . . 3–4 Days
If yes, please provide driver(s) name; CDL #; year, make, model and VIN # of the vehicle in the Remarks Section on page 5.
- Are driving records of such employees checked prior to hiring? No Yes
Are driving records of such employees checked every 6 months? No Yes
Is proof of insurance checked for such employees before driving? No Yes
Any employees under 16 or over 60 years of age? No Yes
What percent of deliveries is done by employee-owned vehicles? _____%
- Does the applicant: Investigate all accidents and incidents? No Yes
Conduct employee loss prevention meetings quarterly? No Yes
Have any part-time or seasonal workers? No Yes
Check employment & personal references prior to hiring? No Yes

Do you conduct any of the following operations:

1. Sell, rent, or repair canes, crutches, walkers, wheel chairs, beds? No Yes
2. Sell, rent or repair medical or therapy equipment such as massagers, stimulators, oxygen or other gas tanks? If Yes, what is the percentage of gross receipts? _____ As part of the pharmacy or at a separate location? _____ No Yes
3. Sell, rent or repair any life sustaining, life maintenance, or emergency equipment (other than IVs, IV pumps, syringes, etc.) such as dialysis machines, respirators...? No Yes
4. Fill oxygen or other gas tanks? No Yes
If Yes, how many tanks per year? _____
5. Mix and/or package IV solutions? No Yes
If Yes, what is the percent of gross receipts? _____
6. Do you perform compounding? No Yes
 - a. If Yes, what is the percent of gross receipts _____
 - b. Do you compound for your own patients only? No Yes
Do you compound and sell to other pharmacies? No Yes
If Yes, what is the percent of gross receipts _____
7. Employ anyone or contract with anyone to administer or train others to administer IVs? No Yes *
If Yes, provide name of insurance company, policy number, expiration date and limit of insurance that provides coverage.
8. Draw blood for any purpose including but not limited to glucose testing and cholesterol testing? No Yes *
If Yes, provide name of insurance company, policy number, expiration date and limit of insurance that provides coverage.
9. Conduct health care clinics or have health care clinics conducted on your behalf? No Yes
10. Administer inoculations or immunizations by means of syringe? No Yes
11. Perform services or treatments other than preparing, preserving, compounding or dispensing drugs or pharmaceutical products? If Yes, provide details in Remarks section. No Yes *

SECTION VI: Additional Interests

Property: (If Needed)

Mortgage Holder Loss Payee Subject: _____

Name: _____

Address: _____

City/State/Zip Code: _____

Mortgage Holder Loss Payee Subject: _____

Name: _____

Address: _____

City/State/Zip Code: _____

Mortgage Holder Loss Payee Subject: _____

Name: _____

Address: _____

City/State/Zip Code: _____

Liability: (If Needed)

Location: _____ Cert. Holder Landlord Lessor/Equip.
 Other: _____

Name: _____

Address: _____

City/State/Zip Code: _____

Location: _____ Cert. Holder Landlord Lessor/Equip.
 Other: _____

Name: _____

Address: _____

City/State/Zip Code: _____

Location: _____ Cert. Holder Landlord Lessor/Equip.
 Other: _____

Name: _____

Address: _____

City/State/Zip Code: _____