

PHARMACY SUPPLEMENT

1) Is the pharmacy a *closed door pharmacy* or *open door pharmacy*?

closed door open door

a. If closed door, what kind of meds are you doing?

b. Are you mixing? yes or no

c. If mixing, what is
procedure? _____

2) Is there a pharmacist on staff? yes or no

3) Does the pharmacist carry their own Professional Liability policy?

yes or no

*If yes, we will need a copy of a certificate showing proof of coverage.
If no, you will need to purchase professional liability coverage for the
pharmacist and provide us with a certificate of insurance prior to binding.*

4) What is the gross revenue for on /off the shelf drugs? (aspirin, cold medicine, etc) _____

5) What is the gross revenue for prescription drugs? _____

6) If an open pharmacy, is there any other business exposure, such as gift shop, restaurant, etc? yes or no

If yes, what is the exposure? _____

Signature

Date

Medical Equipment Repair Application
(Application for Casualty & Property Insurance)

1. GENERAL INFORMATION & PROPERTY SECTION. *(If you **do not** require property insurance, complete only the location information then go to page 2)*

2. Location #1: Building Address _____
Building Age: _____ When Updated?: _____ What was Updated?: _____

Square Footage: _____ Construction: _____ No. Stories: _____ Protection
Class: _____ Other Occupancies: _____

Do you have a burglar alarm? Y [] N [] Describe type of alarm _____

Location #2: Building Address _____

Building Age: _____ When Updated?: _____ What was Updated?: _____

Square Footage: _____ Construction: _____ No. Stories: _____ Protection
Class: _____ Other Occupancies: _____

3. What Deductible is desired: \$500 [] \$1,000 [] Other: _____
What Coverage is Desired: [] Basic [] Broad [] Special

4. Do you pick up or deliver customers goods? [] Yes [] No
Describe vehicle used in pickup/delivery: _____
Maximum Amount of customers goods in vehicle at any one time?: _____

Is Transportation Coverage wanted? [] Yes [] No
Amount Desired: _____ Deductible Desired: _____

5. Loss History: (Give date of loss, type of loss, amount paid in reserve.)

GROUP INSURANCE PROGRAM

APPLICATION FOR PROFESSIONAL & COMPREHENSIVE LIABILITY INSURANCE FOR ORTHOTIC & PROSTHETIC PROVIDERS

Instructions: Please answer all questions. If the question is not applicable, please indicate. If additional space is needed, please attach a separate sheet. Application must be signed and dated by authorized party.

1. Full Name of Applicant: _____
DBA: _____
Years in Practice: _____ How many years operating under the same ownership? _____
Phone: _____ Fax: _____
2. Principal building information – Burglar Alarmed: Yes ; No Sprinklers: Yes ; No
Building Address: _____
Bldg. Age: _____ Basement: Yes ; No Square Feet: _____ No. Stories: _____
Bldg. Construction: _____ Other Occupancies: Yes ; No
3. If any additional locations, please complete additional location supplement.
4. Applicant is: Corp ; Partnership ; Professional Assoc ; Other
5. Does applicant own or operate any other business? Yes ; No
6. State amounts of total revenue:

Gross Revenue This Fiscal Year	Gross Revenue Next Fiscal Year
\$ _____	\$ _____
7. Does Applicant render professional service directly to patients without doctor's referral? Yes ; No
8. Does Applicant perform or assist in any surgical procedures? Yes ; No
If so, list all procedures _____

- 9a. Has any claim or suit been brought against the Applicant and/or any of his/her employees?
Yes ; No If yes, a supplemental claim form must be completed for each claim or suit.
- 9b. Was the above claim or suit – Professional ; Auto Liability ; or General Liability
10. Is the Applicant aware of any circumstances, which may result in a malpractice claim or suit being made or brought against the applicant or any of his/her employees? Yes ; No If yes, give details on a separate sheet.

GROUP INSURANCE PROGRAM

11. What professionals do you employ?

- RT's How Many _____ Nurses How many _____
 Orthotists How Many _____ Prosthetists How many _____
 Other How Many _____

12. List prior Liability Insurance carried for each of the past three years.
If none, state none.

Insurance Carrier	Policy #	Limits of Liability	Deductible (if any)	Premium	Claims Made Policy Form? (Yes/No)	Effective Date

13. If prior liability insurance was on a claims made basis, advise the retroactive exclusion date of the coverage: _____

14. What limits of liability would you like?

\$500,000 CSL ; \$1,000,000 CSL ; \$1,000,000/\$2,000,000 ; \$1,000,000/\$3,000,000

15. Umbrella coverage if desired: Yes ; No

(If yes, please complete the Umbrella Supplement sheet)

16. Are you or is someone on staff ABC certified? Yes ; No

WARRANTY: It is warranted that the information contained herein is true and that it shall be the basis of the policy of insurance and deemed incorporated therein, should the company evidence its acceptance of this application by issuance of a policy. I/we hereby authorize the release of claim information from any prior insurer.

Please review the policy carefully. Except to such extent as may be provided otherwise in the policy, the policy for which the application is being made is limited to only those claims that are first made against the insured while the policy is in force.

Applicant (Print) _____

Signature of Applicant _____

Title _____

Date _____

* Signing this form does not bind the applicant or the company or the underwriting manager to complete the insurance application. Must be currently signed and dated to be considered for quotation.