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