The Hanover Insurance Group™

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Home Care Advantage

Commercial Lines

PHARMACY APPLICATION
Retail; Closed; Long Term Care; Home Infusion

Hanover Agency Code:_____

A. APPLICANT INFORMATION

1. Renewal Date: _____ Policy Number: _____
2. Are you currently a member of the NHIA? ☐ Yes ☐ No ☐ Other Association _____
   _____
3. Company Name (Named Insured and other Named Insureds): _____
   _____
4. Mailing Address: _____
5. Contact Person: _____ Title: _____
6. Year Business Established: _____ Phone: _____ Fax: _____
7. Website Address: _____ Email Address: _____
8. Business Entity: ☐ Individual ☐ Partnership ☐ Corporation ☐ Joint Venture ☐ Other _____
9. Please list all locations **DIFFERENT** from mailing address (**NOTE:** You **MUST** indicate a physical address if mailing address is a post office box) _____
   _____
10. Policy Limits Desired: ☐ Renew based on expiring policy ☐ Other Limits: _____

NOTICE: A copy of the license for each and every professional employee MUST be attached to this application in order for coverage to apply.

B. POTENTIAL LOSS

1. Do you have any outstanding claims, losses, or incidents that have not been reported? ☐ Yes ☐ No
   If Yes, you MUST attach notice of claim

C. RISK MANAGEMENT/UNDERWRITING

1. Has applicant ever been inspected by a pharmacy inspection/accreditation agency? ☐ Yes ☐ No
   If Yes, have there been any cited violations? ☐ Yes ☐ No
2. Does applicant install, service or demonstrate products? ☐ Yes ☐ No
3. Does applicant directly import pharmaceutical products from foreign companies? ☐ Yes ☐ No
   a. If Yes, does your foreign supplier or manufacturer carry liability insurance? ☐ Yes ☐ No

D. PHARMACY OPERATIONS

1. Do you operate a Retail Pharmacy? ☐ Yes ☐ No
   Annual Prescription sales: $_____ Annual Non-prescription sales: $_____
2. Does applicant compound drugs/medications? ☐ Yes ☐ No
   If Yes, indicate % of revenues from this operation: _____%
3. Does applicant ever compound in batches? ☐ Yes ☐ No
4. Is compounding done by individual prescription only? ☐ Yes ☐ No
5. Is applicant a Pharmacy Benefits Program Administrator? ☐ Yes ☐ No
6. Does applicant sell food/drink or other household items? ☐ Yes ☐ No

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E. PROFESSIONAL LIABILITY

	Total # Employed	# Contracted	Annual # Patient Visits
Nurses			
Pharmacists			N/A
Respiratory Therapists			
Other Healthcare Professionals:			

1. Are any of your employed nurses PICC certified? ☐ Yes ☐ No
2. Do any employed professionals carry their own professional liability? ☐ Yes ☐ No
   If Yes, please attach a copy of their certificate of insurance.
3. Are contractors required to show proof of coverage? ☐ Yes ☐ No
   If Yes, please attach a copy of contract and certificates of insurance.
4. Do you have a medical director? ☐ Yes ☐ No
   If Yes, is he/she ☐ employed or ☐ contracted
5. Are any of your employed professionals less than 100% employed? ☐ Yes ☐ No
   If Yes, do any of them "moonlight" (work for other organizations)? ☐ Yes ☐ No
6. For those employed professionals who "moonlight" do you require they carry professional liability coverage of their own? ☐ Yes ☐ No

F. PRODUCTS LIABILITY

1. Do you rent/lease or sell any durable medical equipment or supplies to your patients? ☐ Yes ☐ No
2. Total annual gross receipts generated by the rental/sale of durable medical equipment only:
   Total Receipts: $_____
3. Breakdown by type of durable medical equipment rented, leased or sold (annual amount):
   - Infusion pumps/poles $ _____
   - Wheelchairs, beds, walkers, commodes $ _____
   - Respiratory related equipment $ _____
   - Patient lifts, wheelchair lifts, elevators or stairglides $ _____
   - Life support, life monitoring or diagnostic equipment $ _____
   - Invasive equipment not included in any other category listed above $ _____
4. Do you sell or rent products manufactured by others under your own label? ☐ Yes ☐ No
   If Yes, please explain what products: _____
5. Are manufacturers' labels kept on products? ☐ Yes ☐ No
   If No, please explain why: _____
6. Do you manufacture any products? ☐ Yes ☐ No
   If Yes, please explain (list products): _____
7. Are you included as an "Additional Insured" or "Vendor" under any of your manufacturers' products liability policies? ☐ Yes ☐ No
   If No, we suggest that you ask your supplier to add your firm as an additional insured under their products liability policy or at least provide proof of insurance to you.
8. In the event of equipment malfunction or failure, do you have some type of emergency procedures in place? ☐ Yes ☐ No
   If Yes, please explain:_____

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G. HOME HEALTH CARE

1. Do you provide Home Health Care Services? ☐Yes ☐No
2. Do you employ Professional staff to provide Home Health Care? ☐Yes ☐No
3. Are Subcontractors ever used to provide these services to your patients? ☐Yes ☐No
4. Are background checks performed on all employed staff members that will be working directly with the patients? ☐Yes ☐No

Please provide the annual income/revenue generated from the Home Health Services: $ _____

Total estimated annual gross revenues **(REQUIRED)** $ _____
(Note: All receipts listed above in categories must equal this total)

Total square footage: _____
(All locations of the applicant)

By my signature below:

1) I warrant that the information provided in this application is true and complete and that no information which would influence the judgment or decision of the insurer to consider this application has been withheld.
2) I acknowledge that this application will be the basis of any insurance policy issued as a result of this application and will become part of the policy as if physically attached.
3) I acknowledge that if anything changes that makes the information contained in this application inaccurate or incomplete after the submission date but prior to the policy effective date, I have the duty to notify The Hanover Insurance Group in writing of such occurrence, event or circumstance. I understand that after such notice, any outstanding quotation may be changed or withdrawn at the sole discretion of the insurer or their agent and that failure to provide this information can result in a denial of insurance coverage.
4) I authorize the release and exchange of current and future underwriting and claim information between any prior insurer(s) and The Hanover and my broker, agent or peer review.

HANOVER FRAUD STATEMENT

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines and denial of insurance benefits.

Please see the attached specific Fraud Warnings required by some states.

APPLICANT SIGNATURE: _____ DATE: _____

PRINT NAME: _____ TITLE: _____

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FRAUD WARNINGS

Notice to District of Columbia Applicants: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Notice to Florida Applicants: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim or any application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Notice to Kentucky Applicants: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information or concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Notice to Louisiana And West Virginia Applicants: Any person who knowing presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Notice to Maryland Applicants: Any person who knowingly or willingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines or confinement in prison.

Notice to New Jersey Applicants: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

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 materially false information or conceals, for the purpose of misleading, information or concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Notice to Ohio Applicants: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Notice to Pennsylvania 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 insurance act, which is a crime and subjects such person to criminal and civil penalties.

Notice to Tennessee and Virginia Applicants: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.