california pharmacists association

California Pharmacists Association
Business Owners Package Program Application

MERCER
MAKE TOMORROW, TODAY

Mercer Sales Assoc/Sub-Producer: _____ Proposed effective date: _____

SECTION I: General Information

Applicant's Name: _____ ☐ CPhA Member ☐ Non-Member

Entity Name: _____

DBA Name: _____

Address: _____ Tax ID #: _____

City: _____ County: _____ Zip: _____

Phone:(_____)_____ Fax:(_____)_____ e-mail: _____

☐ Individual ☐ Corporation ☐ LLC ☐ Partnership ☐ Other(describe) _____

☐ Community Pharmacy ☐ Closed Door Pharmacy – Type: _____

1. Previous Insurance Carriers (last 3 years)	Date of Loss *(if any)*	Amount of Loss *(if any)*	Description of Loss *(if any)*

2. Current Premium: _____ Target premium: _____

3. How many years has the applicant been in business? _____ years (If less than 3 years, provide resumé and details of previous experience in remarks section on page 4).

4. Is applicant a parent or subsidiary of another entity? If Yes, provide details in remarks section (page 4). ☐ No ☐ Yes

5. Does applicant participate in any direct mail or filling prescriptions via the internet? ☐ No ☐ Yes

6. Does the applicant employ travel nurses who administer injections? ☐ No ☐ Yes

7. Has any insurance company declined, cancelled or non-renewed coverage for this or similar coverage? If Yes, provide details (page 4) ☐ No ☐ Yes

WARRANTY STATEMENTS:

1. Within the last five years, have any of the following ever been revoked, suspended, refused, cancelled or voluntarily surrendered?
   a. State license or certification ☐ Yes ☐ No
   b. Malpractice insurance ☐ Yes ☐ No

2. Within the past five years, have any complaints or charges been brought against any principal, current employee or past employee of the applicant by any licensing board or professional ethics body for violations of ethics codes, unprofessional conduct, intentional misconduct or incompetence? ☐ Yes ☐ No

3. 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? ☐ Yes ☐ No
   a. Any employee ☐ Yes ☐ No

4. Has any principal, current employee or past employee of the applicant ever been convicted (as an adult) of a misdemeanor or felony or is such a case pending? ☐ Yes ☐ No

5. Have you had a foreclosure, repossession, bankruptcy, judgment or tax lien, business failure or any litigation during the past 5 years? ☐ Yes ☐ No

6. Have there been any past losses or claims relating to sexual abuse or molestation allegations, discrimination or negligent hiring? ☐ Yes ☐ No

7. Does the prospect sell, design, manufacture, distribute, serve or furnish any products containing cannabis, synthetic cannabinoids or equivalents, such as, but not limited to K2, Spice, or other similar products in any form for bodily ingestion, inhalation, absorption or consumption either on-site or off-site? ☐ 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 or remarks section on page 4.

SECTION I: General Information (Continued)

OPERATIONS: **(Combined total of all items marked in each column must equal 100%)**

a. Total Annual Sales Receipts: $_____

_____ % Prescription Drugs (Rx)
_____ % Non-Prescription Drugs
_____ % Sale of DME
_____ % Rental of DME
_____ % Liquor
_____ % Other_____
100% **TOTAL**

b. Total Annual Rx Sales Receipts: $_____
(Multiply Total Annual Sales Receipts from column a., by percentage of Prescription Drugs in column a., for Total Annual Rx Sales Receipts.)

_____ % Prescription Drugs (Rx)
_____ % Sterile Compounding
_____ % Non-Sterile Simple Compounding
_____ % Non-Sterile Complex Compounding
100% **TOTAL**

c. Does any sterile compounding involve intrathecal or epidural injectables? . . . . . ☐ Yes ☐ No

SECTION II: Property Information

Location #: _____ **(If multiple locations, please copy this page and complete it for EACH additional location.)**

1. Number of years applicant at this location: _____ Applicant is: ☐ Tenant ☐ Lessor ☐ Owner-Occupant (more than 10%)
2. Applicant is located in: ☐ An enclosed mall ☐ A strip mall ☐ Located in free standing building
3. Physical Address (If different than on page 1): _____

_____

4. Is the operation within 1,000 feet of a fire hydrant or other approved water source? . . . . . ☐ Yes ☐ No
5. Is the operation within 5 miles of a responding fire station? . . . . . ☐ Yes ☐ No
6. Construction:* ☐ Frame ☐ Joisted Masonry ☐ Masonry Noncombustible ☐ Noncombustible ☐ Fire Resistive
7. Sprinkler system: ☐ Sprinklered ☐ Non-Sprinklered
8. Year of Building:_____ If age exceeds 20 years, indicate year when the following were significantly upgraded by a qualified contractor: _____Plumbing Systems _____Heating Systems _____Electrical Systems _____Roofing
9. Number of residential units:_____
10. Burglar Alarm/Protection: ☐ None ☐ Local ☐ Central Station ☐ Hold up button ☐ Motion, Infrared or Laser Sensors ☐ Tamper proof line
11. Security cameras: . . . . . ☐ Yes ☐ No
12. Has the property undergone lead abatement procedures? . . . . . ☐ Yes ☐ No
13. Number of stories:_____
14. Number of Employees:_____(at this location)
15. Total Building sq. ft. where your operation is located:_____
16. Risk Management Equipment/Accreditations and Memberships:
    a. Do you have a Pill Dispensing Machine (Pass Rx) for this location? . . . . . ☐ Yes ☐ No
    b. Do you hold an accreditation by URAC (Utilization Review Accreditation Commission)? . . ☐ Yes ☐ No
    c. Do you hold an accreditation by PCAB (Pharmacy Compounding Accreditation Board)? . ☐ Yes ☐ No
    d. Are you a PCCA (Professional Compounding Centers of America) member? . . . . . ☐ Yes ☐ No

*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)

Coverage Elections: (Earthquake coverage not available)

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

1. ☐ Building: Limit of Insurance $_____
   a. Deductible: ☐ $500 ☐ $1,000 ☐ $2,500 ☐ $5,000
   b. Area of building: _____sq. ft. (Max: 15,000)
   c. Occupy **LESS** than 10% ☐ . . . . Occupy **MORE** than 10% ☐
2. ☐ Business Personal Property: (Including tenants improvements & betterments – Replacement Cost Value)
   a. Limit of Insurance $_____
   b. Deductible: ☐ $500 ☐ $1,000 ☐ $2,500 ☐ $5,000
   c. Area of Occupancy: _____sq. ft. (Max: 15,000)

3. 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:	$10K/$5K included or $_____/$_____ (Max. $20/$20)
Employee Dishonesty:	Minimum included or $_____ (Maximum $100,000)
Glass Coverage:	Included (subject to a $500 deductible)
Exterior Signs:	Included (deductible may apply)

SECTION III: Liability Information and Optional Coverages

Business Liability: ☑ $2,000,000 per occurrence – Included BI/PD CSL
$2,000,000 products/completed operations
$4,000,000 general aggregate
$10,000 per occurrence – Medical payments

☐ Umbrella Limit: $_____(Max $5M)
☑ Business Owners Blanket Endorsement
☑ Pharmacy Blanket Coverages
☑ Data Compromise $50K limit/$1K deductible
☐ Retail Stores Endorsement

1. ☐ Earthquake Sprinkler Leakage (EQSL)
2. Hired and Non-Owned Auto: ☐ Include ☐ Exclude **(Not eligible if Business Autos are covered elsewhere, or if no employees.)**
3. What percent of deliveries is done by employee-owned vehicles? _____%
4. ☐ Employment Practices Liability (EPLI) $100K limit/$5K deductible (Add'l limits available: ☐ $150K limit/$5K ded. ☐ $250K limit/$5K ded. / ☐ $500K limit/$5K ded.)
   Wage and Hour Coverage is not available.
5. Are business-owned vehicles used by employees for business related activities? . . . . . ☐ 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 . . . . . ☐ No ☐ Yes
   gas tanks? If Yes, what is the percentage of gross receipts?_____ As part of the pharmacy or at a separate location?_____
3. Do you perform compounding? . . . . . ☐ No ☐ Yes
   a. Do you compound for your own patients only? . . . . . ☐ No ☐ Yes
   b. Do you compound and sell to other pharmacies? . . . . . ☐ No ☐ Yes
   If Yes, what is the percent of gross receipts_____

** Provide details in remarks section on page 4*

SECTION III: Liability Information (Continued)

Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance 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 the person to criminal and civil penalties.

I authorize Mercer to collect, use and disclose loss run information from my former business owners package insurance policies solely for the purpose of obtaining replacement coverage. I authorize Mercer to obtain proposals on my behalf from the program insurers. They are authorized to release to prospective insurers the name of my current insurer, pricing and policy terms. They may also release to prospective insurers the results of other competitive bids in order to allow an insurer to submit an improved quote. I will advise Mercer in writing if I do not want any of the above information released.

Application completed by	Date	Applicant's Signature

Fax to: **515-365-0681,** scan and email to: **LH.Admin@mercer.com** or mail to: **Mercer, P.O. Box 14438, Des Moines, IA 50306-9803.**

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About Our Role and Compensation

The California Pharmacists Association, a Mercer client, has selected WestGUARD for this insurance program. Alternative insurance products may be available in the insurance market place. Mercer Health & Benefits Insurance Services LLC is providing this single insurer option on behalf of the California Pharmacists Association. 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 such factors as volume, growth or retention of business. 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 if applicable, 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 o4245235 for the Business Owners policy, or o747224 for the Umbrella policy, or call us at 1-888-206-5088 for specific details.

SECTION IV: Remarks

(Con't on Page 5)

SECTION V: 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: _____