



# California Pharmacists Association Business Owners Package Program Application

400671w



AMBA 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 Within the last five years, have any of the following ever been revoked, suspended, refused, cancelled or voluntarily surrendered?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?  
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.  
Wage and Hour Coverage is not available.  \$250K limit/\$5K ded. /  \$500K limit/\$5K ded.)
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 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: \_\_\_\_\_