

Business Owners Package Premium Indication Request



FOR MEMBERS OF THE CALIFORNIA PHARMACISTS ASSOCIATION

400671w

For more information complete the form below and email to LH.Admin@getamba.com

Member Information

Member Name _____
Pharmacy Name _____
Address _____
City _____ State CA Zip _____
Phone (_____) _____ Fax (_____) _____
e-mail Address _____ Contact _____
How long have you owned your pharmacy? _____

Business Owners Package *For a premium indication, please include the following information*

Business Type ☐ Individual ☐ Corporation ☐ LLC ☐ Partnership ☐ Other (describe) _____
Pharmacy Type ☐ Community Pharmacy ☐ Closed Door Pharmacy ☐ Other _____
Limits ☒ \$2 million/\$4 million ☒ Include expanded Pharmacy Services wording
Annual Prescription Drug Receipts \$ _____ Number of Scripts filled daily _____
Number of full-time pharmacists _____ Number of full-time technicians _____
Current policy expiration date _____ Current Carrier _____
Any claims in the last 3 years? ☐ No ☐ Yes Business Personal Property \$ _____
Check one ☐ Tenant ☐ Building Owner – Building Limit, if Owner: \$ _____
Sprinklered ☐ No ☐ Yes Alarm ☐ Central ☐ Local Age of Building _____
Building Construction ☐ Frame ☐ Joisted Masonry ☐ Masonry Noncombustible ☐ Noncombustible ☐ Fire Resistive

Signature

This is not an application for insurance.

I authorize AMBA to obtain a Business Owners Package premium indication(s) on my behalf.

Signature X _____ Date X _____



The insurance policy, not this letter, forms the contract between the insured and the insurance company. The policy may contain limits, exclusions, and limitations that are not detailed in this letter. Coverages may differ by state.