Return Application to:
Rockwood Programs, Inc
3001 Philadelphia Pike
Claymont, DE 19703
Tel:800-365-0816
Fax: 302-764-9125
medmal@rockwoodinsurance.com

PHARMACY INDICATION APPLICATION

FOR INDICATION ONLY – FULL APPLICATION WILL BE REQUIRED FOR FORMAL TERMS

BACKGROUND INFORMATION – PLEASE READ:

1. Please type or print clearly.
2. Answer ALL questions completely leaving no blanks. If any questions, or part thereof, do not apply, print N/A in the space.
3. If additional space is needed to answer any questions fully, please attach a separate page.

Requested Attachments:

1. Loss History for the last FIVE years
2. Copy of expiring declarations page if retroactive coverage is being requested

I. APPLICANT INFORMATION

a) Name of Applicant/Entity(s) _____

b) Date of Incorporation/Start of Operations: _____

c) Physical Address (City, State, Zip Code) _____

II. COVERAGE HISTORY

i) Date organization was established: _____
ii) Has the organization had prior insurance coverage? _____
   a. If so, what is the retroactive date: _____

III. PROFESSIONAL SERVICE

i) Confirm the total number of prescriptions filled annually: _____
ii) Does your organization provide any Drug Benefits or Pharmacy Benefits services?
☐ Yes ☐ No
iii) Does your organization provide any Compounding services? ☐ Yes ☐ No
   a. If so, any sterile compounding? ☐ Yes ☐ No
   b. If so, any compounding in bulk? ☐ Yes ☐ No

Gross Revenue	Projected Next Year	Current Year	Last Year
Prescription Sales:			
Compounding Sales:			
Sundries Sales:			
Medical Equipment Sales:			
Medical Equipment Rental:			
Home Services:			
Other:			
Total:			

IV. INSURED HISTORY, CLAIMS, LOSSES AND INCIDENTS

a) Has any claim or suit for an error, omission or malpractice ever been made against you or your organization or any employees/staff working on your behalf?

☐ Yes ☐ No If yes, how many? _____ Complete a Supplemental Claim form for each.

b) Are you or any proposed insured for this insurance aware of any claim or suit, or any act, error, omission, fact, circumstance, or records request from any attorney which may result in a malpractice, general liability or products liability claim or suit? If yes, has each of these been reported to the current or any prior insurer?

☐ Yes ☐ No If yes, how many? _____ Complete a Supplemental Claim form for each.

c) Has the applicant or any staff:

1) Ever been the subject of disciplinary/investigative proceedings or reprimand by a governmental/administrative agency, hospital or professional association?

☐ Yes ☐ No

2) Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses?

☐ Yes ☐ No

3) Ever been treated for alcoholism or drug addiction?

☐ Yes ☐ No

Signed: _____

Date: _____

Print Name: _____

Title: _____
(Owner, Partner, Authorized Officer)