

# VGM INSURANCE

## PHARMACY SUPPLEMENTAL APPLICATION

INSURED NAME: \_\_\_\_\_

- 1) Do you operate a *closed* or *open door* pharmacy?     closed door     open door  
2) Are you compounding?     yes     no  
    a. If yes, describe compounding procedure:

\_\_\_\_\_

- 3) Number of pharmacists on staff? \_\_\_\_\_  
4) Pharmacists names: (please list full and part-time pharmacists)  
    a. \_\_\_\_\_  
    b. \_\_\_\_\_  
    c. \_\_\_\_\_

- 5) Is the pharmacy owner a registered pharmacist?     yes     no

**Underwriting guidelines require that we receive a copy of a certificate showing proof of individual professional coverage for each full and part-time pharmacist, from an AM Best rated carrier<sup>1</sup>, or you may purchase the Pharmacists Services Coverage Endorsement from us, for an additional annual premium of \$400 per pharmacist.<sup>2</sup> Please provide Certificate(s) within 30 days of policy inception to avoid additional charges to your account.**

<sup>1</sup>There are a number of nationally recognized carriers who provide Pharmacists Individual Professional coverage. Please ask an agent at VGM for more information.

<sup>2</sup> Fee is waived for practicing owner/pharmacist

- 6) What is the gross revenue for OTC drugs? (aspirin, cold medicine, etc) \$ \_\_\_\_\_  
7) What is the gross revenue for prescription drugs? \$ \_\_\_\_\_  
8) If an open pharmacy, is there any other business exposure, such as gift shop, restaurant, etc?  
    please describe: \_\_\_\_\_

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

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