



New Business Application – Compounding Pharmacy Operations

APPLICATION INFORMATION

- a) Membership no. (must be current): _____ OCP Accreditation no: _____
- b) Effective date requested: _____
- c) Name of pharmacy: _____
- d) Name of legal entity: _____
- e) Mailing/billing address: _____
 City: _____ Prov: _____ Postal Code: _____
- f) Contact person: _____
 Tel: _____ Email: _____
- g) Pharmacy address: _____
 City: _____ Prov: _____ Postal Code: _____
- h) Mortgagee: _____
 Mailing address: _____
 City: _____ Prov: _____ Postal Code: _____
- i) Loss Payee: _____
 Mailing address: _____
 City: _____ Prov: _____ Postal Code: _____
 With respect to: _____

Location Information

Occupancy Owned Leased _____ Sq ft./sq m

Operations, if other than retail pharmacy, please provide details: _____

Construction

Walls: Concrete Solid Brick Brick Veneer Frame or Wood

Floors: Concrete Steel Joist Wood Joist

Roof: Concrete Steel Joist Wood Joist

Approx. year built: _____ No. of Storeys: _____

Type of heating: Boiler Hot Air Electric Gas Other _____

Upgrades/Updates (if building is over 30 years old, list all): Electrical Year _____ Roof Year _____
 Plumbing Year _____ Heating Year _____



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Fire Protection Information

Outside Protection Fire hydrants within 500 feet? Yes No
 Fire department within 5 miles? Yes No

Inside Protection Do you have sprinklers? Yes No
 Are the sprinklers alarmed? Yes No
 Do you have smoke/heat detectors? Yes No

Alarm system (hooked up to all openings): _____

Type: _____ Level: _____

Communication: _____ Level: _____

Outside central station? Yes No

Name of monitoring company: _____

STATEMENT OF PROPERTY VALUES

SECTION A - EQUIPMENT

Equipment - Used in connection with your pharmacy (excluding stock), **can include:** furniture, fixtures & fittings, signs, computer equipment, condominium or tenant's leasehold improvements, appliances, machines, tools, utensils, shelving

	Current Value	New Value
Equipment – *Replacement Cost	_____	_____

SECTION B - STOCK

Stock can include: goods & merchandise, packing & wrapping, advertising materials & supplies.

Normal Stock Value: not including peak season; amount includes goods or inventory used in connection with your pharmacy.

Peak Stock Value: this amount should include the amount over and above normal stock amount. For example, peak may run from Oct. through to Jan. of the following year.

	Current Value	New Value
Normal Stock	_____	_____
Peak Stock	_____	_____

Please confirm month(s) of peak season _____

What percentage of stock value above represents refrigerated/ temperature controlled products? % _____

SECTION C – CONSEQUENTIAL LOSS COVERAGE – Policy provides a base limit of **\$25,000** for Loss of stock resulting from a breakdown of refrigeration. To purchase higher limit, please select an option below:

\$50,000 \$75,000 \$100,000

Do you have an off premises temperature alarm system connected to a central station? Yes No

SECTION D – BUILDING (If owned)

Building can include:

- All permanent fittings and fixtures attached thereto such as, elevators, permanent lighting appliance, HVAC equipment, stationary scales, hoses and other fire extinguishing appliances, signaling & time systems, attached to building, fixed floor coverings, fuel for heating the building, janitor's supplies, building maintenance supplies, fencing and other man-made structures on the Premises
- The value of foundations below the level of the lowest floor
- Cost of demolition and debris removal of building and other structures
- Increased cost of construction as a result of any by-law regulation or ordinance of law which regulates zoning, demolition repair or construction of buildings

	Current Value	New Value
Building – *Replacement Cost	_____	_____



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SECTION E – RENTAL INCOME

Rent of the occupied portion of the building and/or the estimated annual rental value of the unoccupied portion of the building.

Current Value New Value

Rental Income _____

SECTION F – OTHER

Current Value

New Value

Average Accounts Receivable _____
Peak Accounts Receivable _____

***IMPORTANT:** Replacement Cost is defined as the cost to replace property of similar kind and quality at today's prices with no deduction for depreciation.

Financial Information

Annual Sales \$ _____ Business Interruption (50% of Annual Sales) \$ _____
Annual Payroll \$ _____ Any U.S. Sales \$ _____

Percentage of income derived from pharmaceutical compounding _____

Percentage of income derived from Opioids/Narcotics _____

Please list your top ten (10) dispensed products

Operational Information

No. of Pharmacists: Full-time _____ Part-time _____
No. of Pharmacy Technicians: Full-time _____ Part-time _____
No. of other employees: Full-time _____ Part-time _____

Are all employees covered by Workers' Compensation? Yes No

Do you do any deliveries? Yes No

Does your pharmacy provide a delivery service? Yes No

If yes, whose vehicle is used? Company Employee Pharmacy Owner's personal vehicle
 Contracted to a Third Party Other (please provide details) _____

If employee vehicle used, do you ask for evidence of liability insurance for \$1 million? Yes No



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Crime Prevention Information

Position of person who is conducting the following:

- a) banking deposits? _____
- b) banking withdrawals? _____
- c) reconciling bank accounts? _____

Who performs accounts receivable/payable functions? _____

Are cheques always countersigned? (2 signatures required) Yes No

If not, is the owner the only one with signing authority? Yes No

Do you have your books reviewed by an Accountant/Bookkeeper annually? Yes No

Is stock/merchandise inventoried? Yes No

If yes, how frequently? _____

Number of employees who have access to money & securities including management & cashiers? _____

How frequently is money transported to the bank? _____

Do you ask for prior employment references and do background checks on all new employees? Yes No

Number of years owning a pharmacy? _____

Safe (maximum overnight coverage allowed is \$2,000, if safe is not class 2 or better)

Do you have a safe? Yes No

Is the safe made of steel? Yes No

Is the body 1-inch thick or more? Yes No

Is the door 1½ inches thick or more? Yes No

Does the safe have a combination lock? Yes No

Does the safe have an Underwriter's Laboratories (U.L.) label? Yes No

Is the safe a Tool Resistant Safe Class T.L. – 15 Burglary? Yes No

Alarm System (hooked up to all openings)

Type _____ Level _____

Communication _____ Level _____

Where are motion detectors positioned? (e.g. directly outside of all openings) _____

Outside central station? Yes No

Name of monitoring company _____

Is it protected? Yes No

Is the equipment ULC approved? Yes No

Are there bars on all openings? Yes No

Do you have glass sensors for all windows? Yes No

Do you have motion detectors on all doors? Yes No

Are all accessible openings protected? Yes No

Are all non-accessible openings protected? Yes No

Do you have bars on doors? Yes No

Do you have bars on windows? Yes No

Do you have double cylinder locks on all your doors? Yes No

Is communication line a dedicated line? Yes No

Is it continuously supervised? Yes No

Is your line shared by numerous customers? Yes No

Can the subscriber be identified? Yes No

Can the subscriber be detected within 6 minutes? Yes No

Is there a skylight? Yes No

Certificate attached? Yes No



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Money

Amount on Premises \$ _____ Amount of money off premises/ transported to the bank \$ _____
 How much money is kept overnight? \$ _____
 Is a night depository used? Yes No
 Do you sell stamps, tokens, tickets and lottery tickets? Yes No
 If yes, indicate amount on premises \$ _____

Professional Detail

Do you currently dispense prescription drugs via Mail order Website N/A
 If yes, please identify percentage of sales derived from that method % _____
 Do you fill prescriptions from the United States for U.S. residents? Yes No
 Do you currently carry individual Malpractice insurance through the OPA? Yes No

Equipment Rentals

Do you rent out equipment to customers? Yes No
 If "yes", what type of equipment do you rent out? _____
 Total value of equipment \$ _____ Annual revenue of equipment rentals \$ _____
 Do you inspect and clean equipment when returned? Yes No Do you keep a log? Yes No

Claims History Information

Please provide details of all claims paid and outstanding during the past five years (*attach separate sheet if necessary*)

Cause	Date	Amt Paid	Details

DECLARATION FOR NEW BUSINESS

- a) We hereby declare:
 - (i) That the statements and particulars in this application are true and represent a complete disclosure of matters that may be material to the assessment of the risk to be considered for insurance;
 - (ii) We agree that this application shall be the basis and form part of any Certificate of Insurance.
- b) It is understood and agreed that the completion of this application does not bind the Insurance Company to provide any insurance nor the Applicant(s) to purchase any insurance offered as a result.
- c) It is understood and agreed that, if subsequent to the date this application is signed (indicated below), and prior to the date coverage is to be effective, the Applicant becomes aware of any information which would change the information provided in this application, the Company shall be immediately notified in writing of such.

Name of Owner _____
 (Please print)

Signature of Owner _____

Date _____