Insurance Questionnaire

Pharma PROTECT

Complete legal name and D/B/A of Applicant: ______________________
Principal Business Address: ______________________
Additional Locations: ______________________

Years in Operation: __________ | Phone: __________ Email: __________

If Liability Coverage is currently in force, please specify:

Carrier: __________ | Limit: __________ Retroactive Date: (mm/dd/yyyy) __________

Questionnaire

COMPOUND PHARMACIES

	Yes	No
Are you interested in receiving information regarding our exclusive pharmaceutical liability and products liability insurance policies?		
Would you like us to perform a comprehensive review of your existing insurance liability programs to be performed by a licensed insurance agent at no cost to you?		
Are you interested in receiving information regarding General Liability/Business Owners Policy? (Covers “Slip and Fall”, Business Interruption, Business Personal Property)		
Are you interested in receiving detailed information on our exclusive “Pharma Protect” risk management Security Design Plan, Security Design Implementation, Mock Inspection and Regulatory Compliance Package?		

Are there any other insurance or financial planning products we can help or guide your growing practice with?

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Name of Requester __________

Date: (mm/dd/yyyy) __________

Best Method of Contact
(Please provide an email address or telephone number) __________

Submit

Tailoring Your Freedom to Practice