APPLICATION FOR PHARMACY TECHNICIAN PROFESSIONAL LIABILITY INSURANCE

OR APPLY ON-LINE AT www.phmic.com

DESIGNED SPECIFICALLY AS AN EXCESS POLICY

ANSWER ALL QUESTIONS - *Please print* - An incomplete application will be returned.

PAYMENT - Check, payable to Pharmacists Mutual, or credit card authorization must accompany application.

Limits of Liability	**Annual Premium Amounts**	
$1,000,000 Per Occurrence/$3,000,000 Aggregate	Pharmacy Technician	$75.00
	First year discounted rate	$45.00

1. Name (*First* *M.I.* *Last*) ☐ Mr. ☐ Ms. ☐ Mrs.
   Address
   City
   State ☐☐ Zip ☐☐☐☐ - ☐☐☐☐ County
   Is this address located within city limits? ☐ yes ☐ no E-mail
2. Phone (home) ☐☐☐ - ☐☐☐ - ☐☐☐☐ (work) ☐☐☐ - ☐☐☐ - ☐☐☐☐ Birthdate ☐☐ / ☐☐ / ☐☐
3. Effective date of the policy ☐ upon receipt by company ☐ other _____
4. Provide the following information if applicable:
   a) ☐ National ☐ State recognized certification/requirement completed. Date: ☐☐ / ☐☐ / ☐☐
   b) License or registration number ☐☐☐☐☐☐☐☐☐☐ State ☐☐ ☐ not applicable
   c) School or Pharmacy Technician Program: _____

   If a through c does not apply, please complete d:

   d) Other recognized program or training: _____
   (Call for a list of Pharmacists Mutual approved programs. If you are applying on the basis of training, please list on a separate sheet of paper your years of experience, location, employment and the signature of a pharmacist who can attest to your experience. A minimum of 3 years experience may be required.)
5. Are you an owner, partner or corporate officer of a pharmacy or a pharmacy related business? ☐ yes ☐ no
   If yes, you are not eligible for this policy unless Pharmacists Mutual provides coverage for your business.
6. Where do you practice? ☐ Independent Pharmacy ☐ Hospital ☐ Nursing Home ☐ Extended Care Facility
   ☐ Chain ☐ Relief ☐ Pharmacist Placement Service ☐ Other_____
7. Employer _____
8. Do you compound in **bulk**, manufacture or wholesale any drugs or drug products? ☐ yes ☐ no
9. Do you carry Professional Liability Insurance with any other company? ☐ yes ☐ no
10. Have any Professional Liability claims been made against you? ☐ yes ☐ no

Please give details of any "yes" answers on a separate sheet.

WARNING: A person who knowingly submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer may be guilty of a crime and may be subject to criminal and civil penalties.

Technician Signature: _____ Date _____

If recommended by Pharmacist: _____ Field Representative: _____

Is your payment enclosed? Please remit application and payment to: Attn: Technician Program, Pharmacists Mutual Insurance Company, P.O. Box 370, Algona, IA 50511.

This application does not bind coverage. Coverage is effective when policy is issued.

☐ Visa ☐ MasterCard ☐ Discover Name of Cardholder _____

Credit Card # ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Security #s* ☐☐☐ Exp. Date: ☐☐ YR ☐☐

Signature _____

**The final 3 digits of your credit card number are found in the signature area on the back of your credit card.*

For Office Use Only	FR	MA	City	CTY	EFD	EXD