Business Owners Package
Premium Indication Request

FOR MEMBERS OF THE CALIFORNIA PHARMACISTS ASSOCIATION 400671w

For more information complete the form below and email to LH.Admin@getamba.com

Member Information

Member Name _____

Pharmacy Name _____

Address _____

City _____ State CA Zip _____

Phone (_____) _____ Fax (_____) _____

e-mail Address _____ Contact _____

How long have you owned your pharmacy? _____

Business Owners Package *For a premium indication, please include the following information*

Business Type ☐ Individual ☐ Corporation ☐ LLC ☐ Partnership ☐ Other (describe) _____

Pharmacy Type ☐ Community Pharmacy ☐ Closed Door Pharmacy ☐ Other _____

Limits ☑ $2 million/$4 million ☑ Include expanded Pharmacy Services wording

Annual Prescription Drug Receipts $ _____ Number of Scripts filled daily _____

Number of full-time pharmacists _____ Number of full-time technicians _____

Current policy expiration date _____ Current Carrier _____

Any claims in the last 3 years? ☐ No ☐ Yes Business Personal Property $ _____

Check one ☐ Tenant ☐ Building Owner – Building Limit, if Owner: $ _____

Sprinklered ☐ No ☐ Yes Alarm ☐ Central ☐ Local Age of Building _____

Building Construction ☐ Frame ☐ Joisted Masonry ☐ Masonry Noncombustible ☐ Noncombustible ☐ Fire Resistive

Signature

This is not an application for insurance.

I authorize AMBA to obtain a Business Owners Package premium indication(s) on my behalf.

Signature X _____ Date X _____

Sponsored by: california pharmacists association

Administered by: AMBA

The insurance policy, not this letter, forms the contract between the insured and the insurance company. The policy may contain limits, exclusions, and limitations that are not detailed in this letter. Coverages may differ by state.