Humana.

Professional Liability Insurance/Federal Programs Attestation Form

Pharmacy chain name/DBA name: _____

CURRENT INSURANCE INFORMATION

☐ A copy of the pharmacy proof of liability insurance is required.

Carrier name: _____ Policy number: _____

Address: _____

City: _____ State: _____ ZIP code: _____

Occurrence/claims limit: _____ Aggregate limit: _____

I hereby represent that no employee in our organization has been excluded from participation in any federal program and has not had any disciplinary action taken against our company or any businesses to which I am a party. I understand that falsification of this testament shall result in rejection of this application or immediate termination of my agreement with Humana. Furthermore, our company will indemnify Humana for any liability incurred, including legal fees, by Humana as a result of falsification of information. I understand any falsification will be reported to all local, state and federal authorities.

_____ _____

Company representative Date

_____ _____

Signature (prepared by) Date