

FORM B: Open Enrollment Application Checklist

Document	Check (✓), if included
FORM A: DSHS Face Page – Signature Required	✓
FORM B: Open Enrollment Application Checklist	✓
FORM C: Contact Person Information Form	✓
FORM D: Enrollment Application	✓
FORM E: MOA (Example Only)	N/A

FORM C: Contact Person Information Form

Legal Name of Respondent: Walgreen Co

This form provides information about the appropriate contacts in the respondent's organization in addition to those on the FACE PAGE. If any of the following information changes during the term of the contract, please send written notification to the Contract Management Unit.

Contact:	<u>Brook Seyfert</u>	Mailing Address (incl. street, city, county, state, & zip):
Title:	<u>Provider Enrollment</u>	<u>1901 E Voorhees St MS790</u>
Phone:	<u>217-709- Ext.2326</u>	<u>Danville IL 61834</u>
Fax:	<u>217-709-2344</u>	
E-mail:	<u>Brook.seyfert@walgreens.co</u>	
Contact:		Mailing Address (incl. street, city, county, state, & zip):
Title:		
Phone:	<u>Ext.</u>	
Fax:		
E-mail:		
Contact:		Mailing Address (incl. street, city, county, state, & zip):
Title:		
Phone:	<u>Ext.</u>	
Fax:		
E-mail:		
Contact:		Mailing Address (incl. street, city, county, state, & zip):
Title:		
Phone:	<u>Ext.</u>	
Fax:		
E-mail:		
Contact:		Mailing Address (incl. street, city, county, state, & zip):
Title:		
Phone:	<u>Ext.</u>	
Fax:		
E-mail:		

FORM D: Pharmacy Services Enrollment Application

The Pharmacy that will be notified of activation for an Event by the DSHS State Medical Operations Center (SMOC) Director or their designee must complete the OE application. The Pharmacy will submit electronically to Riley.Rainosek@dshs.state.tx.us. If there are questions, contact Ms. Rainosek at (512) 776-2185.

Name: _____ See file for list of all Walgreen Co pharmacies _____

Address: _____

Current License, Certification, Registration Number: _____ (attach copy)

Current Proof of Liability Insurance, such as pharmacist liability insurance, professional liability insurance, malpractice insurance, professional business liability insurance, or equivalent form of liability insurance/coverage: __CHI-005958752-13_____ (attach copy)

Telephone #: _____

E-Mail Address: _____

Do you have reliable transportation? Yes _____ No

Do you have telephone availability? Yes _____ No

Do you speak and read English? Yes _____ No

Do you speak another language(s)? Yes _____ No If yes, please specify __language line _____

Do you have the ability to travel to other locations? Yes _____ No

Have you ever been convicted of a felony or subjected to a deferred adjudication on a felony? _____ Yes No If "Yes," please explain in concise detail on a separate sheet of paper, giving the dates and nature of the offense, the name and location of the court, and the disposition of the case(s). A conviction may not disqualify you, but a false statement will. Note: DSHS may require additional information related to convictions of misdemeanors.

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY AND INDICATE YOUR UNDERSTANDING AND ACCEPTANCE BY SIGNING IN THE SPACE PROVIDED.

I certify that all the information provided by me in connection with my application, whether on this document or not, is true and complete, and I understand that any misstatement, falsification, or omission of information may be grounds for refuse to activate or, if activated, immediate deactivation.

I understand that some state agencies will check with the Texas Department of Public Safety, the Federal Bureau of Investigation or other organizations, for any criminal history in accordance with applicable statutes.

THIS APPLICATION MUST BE SIGNED

Sign Here: *Mickelle Vandem*
Signature – Applicant

08/30/2017
Date



CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
07/03/2017

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER MARSH USA INC. 540 W. MADISON CHICAGO, IL 60661 Attn: Chicago.CartRequest@marsh.com Fax: 212-948-0770	CONTACT NAME: PHONE (A/C, No, Ext): E-MAIL ADDRESS:		FAX (A/C, No):
	INSURER(S) AFFORDING COVERAGE		NAIC #
INSURED WALGREEN CO. 300 WILMOT ROAD DEERFIELD, IL 60015	INSURER A : Zurich American Insurance Company		16535
	INSURER B : American Zurich Insurance Company		40142
	INSURER C : N/A		N/A
	INSURER D :		
	INSURER E :		
INSURER F :			

COVERAGES **CERTIFICATE NUMBER:** CHI-005958752-13 **REVISION NUMBER:6**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADOL SUBR INSD WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	<input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY		GLO 9310091-14	07/01/2017	07/01/2018	EACH OCCURRENCE	\$ 4,000,000
A	<input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR		GLO 9310184-14 (Puerto Rico)	07/01/2017	07/01/2018	DAMAGE TO RENTED PREMISES (Ea occurrence)	\$ 100,000
						MED EXP (Any one person)	\$
						PERSONAL & ADV INJURY	\$ 4,000,000
						GENERAL AGGREGATE	\$ 5,000,000
						PRODUCTS - COM/OP AGG	\$ N/A
							\$
A	<input checked="" type="checkbox"/> AUTOMOBILE LIABILITY		BAP 9310096-14	07/01/2017	07/01/2018	COMBINED SINGLE LIMIT (Ea accident)	\$ 5,000,000
A	<input checked="" type="checkbox"/> ANY AUTO		BAP 9310183-14 (Puerto Rico)	07/01/2017	07/01/2018	BODILY INJURY (Per person)	\$
	<input type="checkbox"/> ALL OWNED AUTOS					BODILY INJURY (Per accident)	\$
	<input type="checkbox"/> HIRED AUTOS					PROPERTY DAMAGE (Per accident)	\$
							\$
	<input type="checkbox"/> UMBRELLA LIAB					EACH OCCURRENCE	\$
	<input type="checkbox"/> EXCESS LIAB					AGGREGATE	\$
							\$
							\$
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY		WC 9310092-14 (Ded) (AOS)	07/01/2017	07/01/2018	<input checked="" type="checkbox"/> PER STATUTE	
A	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	<input checked="" type="checkbox"/> Y <input checked="" type="checkbox"/> N N/A	WC 9310094-14(Retro) (WI)	07/01/2017	07/01/2018	E.L. EACH ACCIDENT	\$ 2,000,000
						E.L. DISEASE - EA EMPLOYEE	\$ 2,000,000
						E.L. DISEASE - POLICY LIMIT	\$ 2,000,000
A	EXCESS WORKERS COMPENSATION		EWS 9310093-14(IL,LA)	07/01/2017	07/01/2018	SIR - \$5,000,000	SEE ABOVE
A	AND EMPLOYERS LIABILITY		EWS 9310447-14 (AZ)	07/01/2017	07/01/2018	SIR - \$250,000	SEE ABOVE

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

CERTIFICATE HOLDER

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE
of Marsh USA Inc.

Manashi Mukherjee

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