The Hanover Insurance Group®

# Pharmacy Advantage

Supplemental Application

## GENERAL APPLICANT INFORMATION

Applicant: STATESERV PARENT, LLC - Pharmacy Division

Mailing Address: 1201 S ALMA SCHOOL RD, SUITE 4000, MESA, AZ 85210

Please identify any other owned and controlled organization(s) that should appear as additional named insureds:
N/A

*If physical location differs or multiple locations apply, please provide details including breakout of sales on a separate sheet.

**If there are multiple named insureds, please provide operations, ownership and retroactive date (if applicable) on a separate sheet.

Preferred Effective Date: 10/1/2026 Federal Employer Identification Number: 87-3115334

Is the Applicant licensed and certified for: ☐ Medicare and/or ☐ Medicaid? Provider #: _____

Website: _____

Is website compatible with ADA guidelines? ☐ Yes ☐ No

Description of all operations and types of clients served: The pharmacies primarily serve hospice patients. The NY pharmacy serves Medicare/Medicaid chronically ill patients. Each is licensed in multiple or numerous states, except for Bend, OR. Medications are delivered via courier service and mail order using FedEx.

Describe any changes in operations planned within the next year: At this time, operational changes are not anticipated

Number of years in operation: See spreadsheet Years under present management: Current pharmacy management has b

Within the past five years has the applicant acquired, sold or discontinued any operations? ☒ Yes ☐ No

If yes, please provide details: Stateserv Holdings, LLC acquired EASY RX PAD, LLC, Dragonfly Infusion Services and Dragonfly Hospice Pharmacy, LLC in September 2023.

1. Type of Firm (check all that apply):

| | | | |
|---|---|---|---|
| ☒ Retail | ☒ Closed Door | ☒ Infusion | ☐ Onsite Infusion |
| ☐ Embedded - Retailer | ☐ Embedded – Medical Facility | ☐ Veterinary | ☐ Nuclear |
| ☐ Outsourcing Facility | ☐ Pharmacy Benefits Administrator | ☐ DME Provider | ☐ Other _____ |

2. Is the Applicant licensed in all states in which you're operating? ☒ Yes ☐ No
   Please list all states in which you operate: PA, OH, MD, NY, OR, TN
3. Please list professional organization memberships: AAHPM, NHPCO, ASPH, NPHI
4. Does the Applicant hold accreditations with:
   ☐ Pharmacy Compounding Accreditation Board ☐ Joint Commission ☐ Other _____
5. Date of most recent on-site inspection or survey: All within the past 12-24 months Corrective action plan required? ☐ Yes ☒ No
   Were all deficiencies noted on the action plan corrected? ☐ Yes ☒ No
   If a corrective action plan was required, please attach a copy with this supplemental.
6. Has the Applicant or any staff member ever been the subject of any warnings or disciplinary actions through any local, state or federal authority, or has their license ever been revoked or suspended? ☒ Yes ☐ No
   If Yes, please explain: _____

## HIRING PROCESS

1. Are formal written procedures in place for staff hiring? ☒ Yes ☐ No
2. Does the Applicant require all staff to complete an employment application? ☒ Yes ☐ No
3. Are personal interviews completed for each prospective staff member? ☒ Yes ☐ No
4. Does the Applicant verify employment-related references? ☒ Yes ☐ No



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5. Are written job descriptions provided for all staff members? ■ Yes ☐ No
6. Does applicant verify any active or pending license suspensions, revocations, or disciplinary actions? ■ Yes ☐ No
7. Do you perform criminal background checks on all employees? ■ Yes ☐ No
8. How often do you require drug tests on all employees? Upon hire and randomly ☐ Don't require drug tests
9. What actions are taken if any reports are unfavorable? HR department assesses and advises

**PRIOR CARRIER INFORMATION**

| | No Prior Coverage | Company | Limits | Coverage Form | Retroactive Date | Annual Premium |
|---|---|---|---|---|---|---|
| Professional Liability | ☐ | Hanover | $3M/$1M | ■ Occurrence ■ Claims-Made | 10/1/26 | $ |
| General Liability | ☐ | Hanover | $3M/$1M | ■ Occurrence ■ Claims-Made | 10/1/26 | $ |
| Abuse & Molestation | ☐ | | | ☐ Occurrence ☐ Claims-Made | | $ |
| | | | | | Or, provide Annual Policy Premium | $ |

1. Has the applicant had any Professional, General Liability, Employee Benefits or Umbrella claims or suits brought against them in the past 5 years? ☐ Yes ■ No
2. Is the applicant aware of any incident (including requests for medical records), circumstance or occurrence which may result in a claim and which has not been reported to another carrier? ☐ Yes ■ No

   If Yes, please provide additional details including dates, current status, and any amount paid/ incurred. (Attach additional page(s) if necessary.) _____

**SERVICES PROVIDED**

1. What are your projected Total Annual Revenues/gross receipts for the upcoming 12 months? **(REQUIRED)**
   $ 420,000,000 (provide breakout below)
2. Have annual gross receipts increased or decreased over 25% in the past year? ☐ Yes ■ No
   If Yes, please provide the reason for the change: _____

| PRESCRIPTIONS | GROSS RECEIPTS | NUMBER OF PRESCRIPTIONS |
|---|---|---|
| Non-Compounded Prescriptions | $ | # 6,173,840 |
| Non-Sterile Compounding (as defined in USP 795) | | |
| • Simple | $ | # 62,112 |
| • Moderate | $ | # 18,472 |
| • Complex | $ | # |
| Sterile Compounding Prescriptions (as defined in USP 797) | | |
| • Low Risk | | 1.350 |
| • Medium Risk | | 0 |
| • High Risk | | 0 |
| Wholesale Pharmacy Sales | $ | # 0 |


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| OTHER SERVICES | GROSS RECEIPTS |
|---|---|
| Restaurant operations | $ |
| Disposable Medical Supplies | $ |
| Durable Medical Equipment | $ |
| Home Infusion Administering Services | $ Visits:# |
| Home Health Care | $ Visits:# |
| Other (please describe) | $ |

3. Staffing:

| POSITION | EMPLOYEES | | CONTRACTORS | | INTERNS | |
|---|---|---|---|---|---|---|
| | F/T | P/T | F/T | P/T | F/T | P/T |
| Pharmacist | 188 | 9 | | | | |
| Pharmacy Technician | 242 | 5 | | | | |
| Respiratory Therapist | | | | | | |
| RN | | | | | | |
| LPN | | | | | | |
| Nurse Practitioner | | | | | | |
| Nutritionist | | | | | | |
| Other (specify) | | | | | | |

4. Does Applicant want coverage to include independent contractors? ☐ Yes ■ No
   If No, what limits does Applicant require them to carry? $_____
5. Does Applicant obtain certificates of insurance from independent contractors? ☐ Yes ■ No
   If no, how does Applicant verify that the required insurance is maintained? _____
   _____
6. Does the Applicant provide health care screenings? ☐ Yes ■ No
   If Yes, check all that apply:
   ☐ Blood glucose ☐ Blood pressure ☐ Body fat composition ☐ Bone density
   ☐ Cholesterol ☐ Other: _____
7. Does the Applicant provide immunizations? ☐ Yes ■ No
   Describe immunizations that are administered _____
8. Does the Applicant sell or rent products manufactured by others under your own label? ☐ Yes ■ No
   If Yes, please explain what products: _____
9. Are any products repackaged, not including repackaging for an individual prescription, Blister packs or compounding services in general? ■ Yes ☐ No
   If Yes, are they? ☐ Sterile ■ Non-sterile ☐ Both
10. Does the Applicant distribute intrathecal/epidural injections manufactured or provided by others? ☐ Yes ■ No
11. Does the Applicant directly import pharmaceutical products from foreign companies? ☐ Yes ■ No
    If Yes, does your foreign supplier or manufacturer carry liability insurance? ☐ Yes ☐ No
12. Does the Applicant receive online prescriptions other than through Surescripts, AdvanceMD, Avatar, RxNT, or patients requesting refills via Applicant's website? ☐ Yes ■ No
    If Yes, provide description: _____


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13. Indicate equipment used by Applicant:
    ☒ Robotic Dispenser ☒ Electronic Pill Counter ☒ Automated Pill Identifier ☒ Unit Dose
    ☒ Other (describe) Laminar Flow Hood ☐ None of these apply
14. Does the Applicant mail or ship any prescriptions? ☒ Yes ☐ No
    a. If Yes, indicate percentage of total prescriptions 94 %
    b. Does the Applicant verify if proper storage conditions are maintained throughout delivery? ☒ Yes ☐ No
    c. Are prescriptions mailed or shipped to out-of-state residents? ☒ Yes ☐ No
15. Does the Applicant offer delivery services? ☒ Yes ☐ No
16. Do you or your employees drive personal vehicles for/on business? ☐ Yes ☒ No
    If Yes, # of employees who use their own vehicles? _____ # of deliveries per day: _____
    a. Do you run MVRs on all employees? ☐ Yes ☐ No
    If Yes, how often? ☒ At the time of hire ☐ Annually ☐ Randomly
    What action is taken if an unacceptable driver is identified? HR Department assesses and advises
    b. Do you have a driver safety training program? ☒ Yes ☐ No
17. Does the Applicant provide services to any of the following? (Check all that apply)
    ☐ Hospitals ☐ Correctional Facilities ☐ Group Homes ☐ Physician Offices
    ☐ Long Term Care Facilities ☐ Schools ☒ Other (describe): Contracted inpatient hospice facilities
    If Yes, please indicate the services provided (check all that apply)
    ☒ Prescriptions ☐ Drug utilization reviews ☐ Other pharmacy services (describe) _____
18. Does the Applicant sublet space to a medical practice, clinic or similar organization? ☐ Yes ☒ No
19. Does the Applicant dispense or sell medical marijuana or THC? ☐ Yes ☒ No
    If Yes, describe: _____

**SCHEDULE II DRUGS/OPIOIDS**

1. What are your 3 most frequently prescribed drugs? (Include both narcotic and non-narcotic drugs and indicate dosage):
   See Attached per Pharmacy
2. What percentage of your total annual prescriptions are opioids? (All Opioids dispensed/Total # prescriptions in last 12 months) 13 %
3. What is your best estimate of the breakdown in diagnoses seen for your patients on opioid therapy?
   Chronic Pain Management 0 % Palliative Care: 2 %
   Active Cancer Treatment: 0 % End of Life Care: 98 %
   Post-Operative Care: 0 %
4. What is your best estimate for the length of time patients have been on opioid therapy (use the last 12 month period)?
   3 days or less 10 % 8-14 days 15 % Greater than 30 days 20 %
   4-7 days 15 % 14-30 days 40 %
5. Do you track morphine milligram equivalents (MME) on your patients' prescribed opioids? ☒ Yes ☐ No
6. For your current patient population, what is the range of MME? 15-200 and 30-300mg
7. Do your pharmacists regularly counsel patients on the use of naloxone? ☒ Yes ☐ No
8. What is your rate of dispensing naloxone (use the last 12 month period)? 0.01 %
9. Do you participate in any state-required controlled substance reporting requirement? ☒ Yes ☐ No
10. Do you have a formal, written policy on consulting patients regarding the use of opioids? ☒ Yes ☐ No
11. Do you have a formal, written policy regarding the amount of opioids dispensed at any one time? ☒ Yes ☐ No


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10. Do you have formal, written policies on the following issues?

| | |
|---|---|
| Pharmacist(s) continuing education on opioid crisis (i.e. Opioid Use Disorder) | ☑ Yes ☐ No |
| The daily morphine equivalent of morphine that can be dispensed | ☑ Yes ☐ No |
| Dispensing of opioids and benzodiazepines | ☑ Yes ☐ No |
| Utilizing prescription drug monitoring program | ☑ Yes ☐ No |
| Ordering and receiving of scheduled drugs (who can order/who can receive) | ☑ Yes ☐ No |

**GENERAL COMPOUNDING** – Check here if no compounding services are offered: ☐

1. Does the Applicant operate according to USP standards or equivalent? ☑ Yes ☐ No
2. Is the Applicant audited regularly for compliance with generally accepted pharmacy compounding practices? ☑ Yes ☐ No
3. Are individual prescriptions obtained for every compound dispensed? ☑ Yes ☐ No
4. Are stability testing studies used to establish beyond use dating for each preparation? ☐ Yes ☑ No
5. How frequently does the Applicant compound products that are back ordered from the manufacturer? ☑ Never ☑ Less than 1 per month ☐ 1-4 per month ☐ More than 4 per month
6. Does the Applicant compound any preparations, or provide any product or services for use by an outside business other than a physician's office? ☐ Yes ☑ No
   If yes, describe: _____
7. Is the Applicant's supplier of pharmaceutical ingredients registered with the FDA and DEA? ☑ Yes ☐ No
8. Are Certificates of Analysis available from the Applicant's suppliers for all formula ingredients? ☑ Yes ☐ No
9. Does the Applicant utilize a separate quality assurance staff? ☑ Yes ☐ No
10. Is quality control checked by an outside company? ☐ Yes ☑ No
11. If a regulatory agency orders a recall, is a plan in place to respond? ☑ Yes ☐ No
12. Is office use compounding performed? ☐ Yes ☑ No
13. Is the Applicant licensed to provide office use compounds for each location prescriptions are sent? ☐ Yes ☑ No
14. Does the Applicant verify each facility is legally authorized to receive office use compounds? ☐ Yes ☑ No
15. Is each preparation patient-specific? ☑ Yes ☐ No
16. If not patient-specific, has the Applicant verified each state in which the preparation is dispensed allows office use? ☐ Yes ☑ No
17. Are any veterinary medications compounded for food-chain animals? ☐ Yes ☑ No
18. Are any veterinary medications compounded for high-value animals (race horses, zoo animals?) ☐ Yes ☑ No
19. Provide details for each type of non-sterile compound indicated below:

| TYPE OF COMPOUND | AVERAGE NUMBER OF DOSAGE UNITS PROVIDED WEEKLY | SPECIFY COMPOUNDED PREPARATIONS PROVIDED |
|---|---|---|
| Hormone replacement therapy | 0 | |
| Veterinary medications | 0 | |
| Topical preparations for pain | 19711 | |
| Topical preparations - other | 16500 | Please See Attached |

**BATCH COMPOUNDING** – Check here if no batch compounding services are offered: ☐

1. Does the Applicant batch compound in anticipation of prescriptions? ☑ Yes ☐ No
   If Yes, indicate the preparations you provide in batches:
   Non-sterile: most all compounds are created in batches with review of patient specific data within a 30 day period / Morphine, Lorazepam, Haloperidol rapidly dissolving tablets
   Sterile: 0


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2. Does the Applicant maintain records indicating which patient(s) or office(s) received the batches compounded? ☒ Yes ☐ No
3. Are any of these preparations packed in multiple dose vials? ☐ Yes ☒ No
   If yes, indicate the types: _____
4. How often is end-result quality testing for sterility, potency and endotoxins performed and documented prior to dispensing? ☐ Always ☐ Skip lot testing method ☒ Randomly
   ☐ Never (explain): DFH does not use extended BUD's therefore does not perform testing - NY pharmacy conducts random testing
5. Are the results verified by an outside testing facility? ☒ Yes ☐ No
6. Is a statistically valid sample size (2% of batch size or greater) utilized? ☒ Yes ☐ No
7. What is the maximum number of patients that receive their medication from the applicant's batch preparation? 100

**STERILE COMPOUNDING** – Check here if no sterile compounding services are offered: ☐

1. Provide details for each type of sterile compound indicated below:

| STERILE COMPOUNDS | AVERAGE NUMBER OF DOSAGE UNITS PROVIDED WEEKLY | SPECIFY COMPOUNDED PREPARATIONS PROVIDED |
|---|---|---|
| Intrathecal and/or epidural spinal injectables | 0 | |
| Other sterile injectables (including HRT pellets) | 0 | |
| Sterile IV dosage forms | 22 | Hydromorphone, Fentanyl, Midazolam Infusions, CADD Pain Pumps |
| Sterile inhalation dosage forms | 0 | |
| Sterile ophthalmic dosage forms | 0 | |
| Others | | |

2. Are any of the Applicant's compounded preparations intrathecal and/or epidural suspensions? ☐ Yes ☒ No
   If Yes, explain: _____
3. Are all environmental testing results regarding sterile compounding documented? ☒ Yes ☐ No
4. Does the applicant have a formal standard operating procedure covering aseptic technique, including gowning, when appropriate? ☒ Yes ☐ No
   If No, explain: _____
5. Does the Applicant have an established program of training and competency assessment for pharmacy staff involved in sterile compounding? ☒ Yes ☐ No
   a. How often are competencies performed? Every 6 months
   b. Do your procedures include periodic observations of staff to ensure compliance? ☒ Yes ☐ No
6. Does your Quality Assurance program follow the parameters outlined within USP 797? ☒ Yes ☐ No
7. Are all additions, deletions or revisions to the QA program communicated to all personnel involved in sterile compounding activities? ☒ Yes ☐ No


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**AUTHORIZATION**

By signing this application, the undersigned declares that they have reviewed this application for accuracy before it was signed, answered the questions in this application to the best of their ability and that, to the best of their knowledge following reasonable inquiry, the statements set forth herein are true, complete, accurate and correct and no material facts have been omitted, misrepresented, or misstated. The undersigned further represents that any fact, circumstance or situation indicating the probability of a claim or legal action now known to any entity official or employee has been declared, and it is being agreed by all concerned that the omission of such information shall exclude any such claim or action from coverage under the insurance being applied for. The signing of this application does not bind the insurance company to issue a policy, but it is agreed that this application shall be the basis of the contract should a policy be issued.

**FRAUD NOTICE–Where Applicable Under The Law of Your State**

Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false or incomplete information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and may be subject to civil fines and criminal penalties.

**Notice to Alabama Applicants:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.

**Notice to Arkansas Applicants:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Notice to California Applicants:** For your protection California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**Notice to Colorado Applicants:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purposes of defrauding or attempting to defraud the policyholder with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**Notice to District of Columbia Applicants: WARNING:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**Notice to Florida Applicants:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or any application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

**Notice to Hawaii Applicants:** For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

**Notice to Kentucky Applicants:** Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

**Notice to Louisiana, Rhode Island and West Virginia Applicants:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Notice to Maine Applicants:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.


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**Notice to Maryland Applicants:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Notice to New Jersey Applicants:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**Notice to New Mexico Applicants:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

**Notice to New York Applicants:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

**Notice to Ohio Applicants:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**Notice to Oklahoma Applicants: WARNING:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony (365:15-1-10, 36 §3613.1).

**Notice to Oregon Applicants:** Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact, may be violating state law.

**Notice to Pennsylvania Applicants:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Notice to Tennessee and Virginia Applicants:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

**Notice to Vermont Applicants:** Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

**Notice to Washington Applicants:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Signature in full: Elliot Amundson Elliot Amundson (Jul 24, 2026 09:59:05 CDT) Date: 07/24/2026

Person signing application (Please print): Elliot Amundson Title: CFO

**ALL QUESTIONS MUST BE ANSWERED AND THE APPLICATION MUST BE SIGNED AND DATED**

Agency Name and Address: _____

Person Submitting Application: _____

Telephone Number: _____ Email: _____



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