



## Medical Equipment Supply Stores Application

Applicant's Name \_\_\_\_\_

Mailing Address \_\_\_\_\_

Location #1 \_\_\_\_\_

Complete a separate application for each location

Web Site Address \_\_\_\_\_

Agency Name \_\_\_\_\_

Agent \_\_\_\_\_

Address \_\_\_\_\_

E-Mail \_\_\_\_\_

Phone \_\_\_\_\_

**PROPOSED EFFECTIVE DATE:** From \_\_\_\_\_ To \_\_\_\_\_ 12:01 A.M., Standard Time at the address of the Applicant

**Applicant is:**    Individual    Corporation    Partnership    Joint Venture  
 Limited Liability Company    Other (Specify): \_\_\_\_\_

Number of years in business: \_\_\_\_\_

LIMITS OF LIABILITY REQUESTED		PREMIUMS
General Aggregate	\$	Premises/Operations
Products & Completed Operations Aggregate	\$	
Personal & Advertising Injury	\$	Products/Completed Operations
Each Occurrence	\$	
Fire Damage (any one fire)	\$	Other
Medical Expense (any one person)	\$	
Errors and Omissions	Each claim \$	Errors and Omissions
	Aggregate \$	
Other Coverages, Restrictions and/or Endorsements		Total
	Deductible \$	\$

1. **Full Named Insured** (if not shown above): \_\_\_\_\_

2. **Type of operation and annual sales:**

- Sale of Medical, Hospital and Surgical supplies ..... \$ \_\_\_\_\_
- Rental/leasing of home care products/equipment to consumers ..... \$ \_\_\_\_\_
- Pharmacy ..... \$ \_\_\_\_\_
- Other—Describe: \_\_\_\_\_

3. Are Patrons fitted with rehabilitative items prescribed by doctors, such as back braces or neck collars?  Yes  No  
If yes, is the person doing the fitting an accredited surgical appliance technician? .....  Yes  No

4. Percentage of equipment sold or leased/rented which is physician prescribed: ..... \_\_\_\_\_%

5. Percentage of operations from sale of non-medical products, such as office furniture, printed materials (labels, charts, prescription forms), scales, etc.: ..... \_\_\_\_\_%  
Do you sell vitamins or nutritional supplements under your own label? .....  Yes  No

6. Do you sell or rent oxygen and respiratory equipment, such as oxygen concentrators, cylinders and aspirators? .....  Yes  No  
If yes, percentage of total operation: ..... \_\_\_\_\_%

7. Do you deal in the sale or rental of any other gases? .....  Yes  No  
If yes, describe: \_\_\_\_\_

Do you do any refilling of oxygen (or other gases)? .....  Yes  No

8. Do you buy or sell used equipment? .....  Yes  No  
Percentage of total operation: ..... \_\_\_\_\_%  
If yes, do you recondition/repair, prior to resale? .....  Yes  No  
Do you sell "as is"? .....  Yes  No  
Do you deliver equipment? .....  Yes  No  
If yes, how often? \_\_\_\_\_

Do you do any construction or installation? .....  Yes  No  
If yes, explain: \_\_\_\_\_

9. Do you subcontract repair or installation operations? .....  Yes  No  
If yes, do you obtain Hold Harmless Agreements from your subcontractors? .....  Yes  No  
Minimum limits required of subcontractors: \$ \_\_\_\_\_

10. Is equipment maintenance performed and documented according to manufacturers guidelines? .....  Yes  No

11. Are customers given any applicable Material Data Safety Sheets prepared by the equipment manufacturer? .....  Yes  No

12. What are your procedures for reporting any malfunctioning devices to the Federal Drug Administration?  
\_\_\_\_\_  
\_\_\_\_\_

13. Sale, rental or leasing of any of the following equipment or machines? Indicate by "X."

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Anesthesia apparatus              | <input type="checkbox"/> Inhalation therapy machines   | <input type="checkbox"/> Resuscitation equipment         |
| <input type="checkbox"/> Apnea monitors                    | <input type="checkbox"/> Kidney machines               | <input type="checkbox"/> Scooters/Tricarts               |
| <input type="checkbox"/> Audiometers                       | <input type="checkbox"/> Latex gloves                  | <input type="checkbox"/> Stair lifts                     |
| <input type="checkbox"/> Beds, crutches, walkers, commodes | <input type="checkbox"/> Low air loss mattress         | <input type="checkbox"/> Suction or Irrigation apparatus |
| <input type="checkbox"/> Cardiac Defibrillators            | <input type="checkbox"/> Metal & foreign body locators | <input type="checkbox"/> TENS units                      |
| <input type="checkbox"/> Diathermy machines                | <input type="checkbox"/> Nebulizers                    | <input type="checkbox"/> Ventilators                     |
| <input type="checkbox"/> Internal therapy                  | <input type="checkbox"/> Oscilloscopes                 | <input type="checkbox"/> Wheelchairs                     |
| <input type="checkbox"/> EKG machines                      | <input type="checkbox"/> Parenteral therapy            | <input type="checkbox"/> Wheelchair lifts                |
| <input type="checkbox"/> Heart Monitoring                  | <input type="checkbox"/> Radiation therapy             | <input type="checkbox"/> X-ray, fluoroscopy              |

If you do sell latex gloves, who manufactures them? \_\_\_\_\_

Where is the manufacturer located? \_\_\_\_\_

Are the gloves purchased from a U.S. based distributor?.....  Yes  No

14. Do you directly import any foreign manufactured equipment?.....  Yes  No

If yes, provide details: \_\_\_\_\_

Do you manufacture orthopedic, ambulation or prosthetic devices? .....  Yes  No

If yes, provide details: \_\_\_\_\_

15. Do you employ or subcontract the services of any Respiratory Therapist or Physician? .....  Yes  No

Do you employ any certified professionals?.....  Yes  No

If yes, explain: \_\_\_\_\_

16. Provide breakdown of annual receipts:

	SALES	RENTAL	SERVICE
Expendable items (bandages, tape, gauze, dressing, etc.)			
Non-expendable items (IV stands, traction apparatus, walkers, crutches, surgical instruments [non-critical], Prosthetic devices, etc.)			
Retail Pharmaceuticals			
Oxygen Equipment sales and rental (air compressors, oxygen concentrators, oxygen [liquid], etc.)			
Electric Wheelchairs and Scooters			
Diagnostic or Treatment Devices (CT scanners, MRIs, X-Ray equipment, EKG machines, IV pumps, blood pressure gauges, etc.)			
Ambulatory Equipment (manual wheelchairs, van lifts, stairlifts, hand control devices, etc.)			
Life Sustaining, Invasive or Critical Monitoring (Dialysis, heart/lung machines, apnea monitors, ventilators, incubators, medical gas systems, life-function monitoring, etc.)			
Home Infusion (distribution of drugs, nutrients, chemotherapy, etc.)			

17. Are you a member of any Health Industry Association? .....  Yes  No  
 If yes, which (HIDA, JCAHCO, IMDA, other): \_\_\_\_\_

18. If a member of the Joint Commission on the Accreditation of Health Care Organizations, are you  
 Certified? .....  Yes  No  
 If yes, attach copy of latest certification.

**Any other premises or operations exposures not stated in this application?** .....  Yes  No  
 If yes, attach a complete description and underwriting/rating information.

SCHEDULE OF HAZARDS								
Loc. No.	Classification	Class Code	Premium Bases: (s) Gross Sales (p) Payroll (a) Area (c) Total Cost (t) Other	Terr.	Rate		Premium	
					Prem/ Ops	Products Comp Ops	Prem/ Ops	Products Comp Ops

19. Do you have other business ventures for which coverage is not required? .....  Yes  No  
 If yes, explain and advise where insured: \_\_\_\_\_

20. During the past five years, have any claims been made or suits been brought against you because of  
 alleged malpractice, error, mistake or premises accident in any manner out of applicant's operation? ....  Yes  No  
 If yes, date: \_\_\_\_\_

Please explain: \_\_\_\_\_

21. During the past three years, has any company canceled, declined, or refused similar insurance to the  
 applicant? (Not applicable in Missouri).....  Yes  No  
 If yes, explain: \_\_\_\_\_

Previous Insurer and Loss History: Indicate all claims or losses (regardless of fault and whether or not insured) or occurrences that may give rise to claims for the prior three years.  See loss run attached

YEAR	COMPANY	POLICY NO.	OCCUR- RENCE OR CLAIMS MADE	PREMIUM	LOSSES PAID	LOSSES RESERVED	DESCRIP- TION

This application does not bind the applicant nor the Company to complete the insurance, but it is agreed that the information contained herein shall be the basis of the contract should a policy be issued.

**FRAUD WARNING:**

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.

**FRAUD WARNING (APPLICABLE IN TENNESSEE AND WASHINGTON):**

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.

**FRAUD WARNING APPLICABLE IN THE STATE OF NEW YORK:**

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.

APPLICANT'S NAME AND TITLE: \_\_\_\_\_

APPLICANT'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_  
(Must be signed by an owner, partner or executive officer)

PRODUCER'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

NAME AND PHONE NUMBER OF INDIVIDUAL TO CONTACT FOR INSPECTION/AUDIT: \_\_\_\_\_

**IMPORTANT NOTICE**

As part of our underwriting procedure, a routine inquiry may be made to obtain applicable information concerning character, general reputation, personal characteristics and mode of living. Upon written request, additional information as to the nature and scope of the report, if one is made, will be provided.