

MEDICAL EQUIPMENT SUPPLY STORES APPLICATION

Applicant's Name _____
 Mailing Address _____

 Location _____

 (Please complete a separate application for each location.)

Agent Name _____
 Address _____

PROPOSED EFFECTIVE DATE:
From _____ **To** _____

12:01 A.M., Standard Time at the mailing address of the Applicant.

Applicant is: Individual Corporation Partnership Joint Venture
 Limited Liability Company Other (Specify): _____

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)	\$ Excluded	\$
Professional Limit	Each Medical Incident	Professional
	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.? _____%

6. Sale or rental of 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
9. Do you subcontract repair or installation operations? Yes No. If Yes, do you obtain Hold Harmless Agreements from your subcontractors? Yes No.
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"/> Cardiac Defibrillators |
| <input type="checkbox"/> X-ray, fluoroscopy | <input type="checkbox"/> Resuscitation equipment | <input type="checkbox"/> Radiation therapy |
| <input type="checkbox"/> Kidney machines | <input type="checkbox"/> Audiometers | <input type="checkbox"/> EKG machines |
| <input type="checkbox"/> Diathermy machines | <input type="checkbox"/> Suction or Irrigation apparatus | <input type="checkbox"/> Ventilators |
| <input type="checkbox"/> Oscilloscopes | <input type="checkbox"/> Metal & foreign body locators | <input type="checkbox"/> Heart Monitoring |

14. Do you manufacture or directly import any medical/ surgical equipment? Yes No
 If Yes, provide details: _____

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

16. Are you a member of any Health Industry Association? Yes No. If Yes, which?
 (HIDA, JCAHCO, IMDA, other) _____

17. 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

During the past five years, have any claims been made or suit 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: _____

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

Previous Insurer: Indicate premium and losses for past three years. Describe all losses.

YEAR	COMPANY	POL. #	OCCURRENCE OR CLAIMS MADE	PREMIUM	LOSSES PAID	LOSSES RESERVED	DESCRIPTION

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.

NAME AND TITLE _____

APPLICANT'S SIGNATURE _____ Date _____