

## Medical Equipment Supply Stores Application

**Complete a separate application for each location.**

Applicant's Name:	_____
	_____
Mailing Address:	_____
	_____
Location Address:	_____
	_____
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): \_\_\_\_\_

ANSWER ALL QUESTIONS—IF THEY DO NOT APPLY, INDICATE "NOT APPLICABLE"

**Limits Of Liability and Deductible Requested:**

General Aggregate (other than Products/Completed Operations)		\$
Products & Completed Operations Aggregate		\$
Personal & Advertising Injury (any one person or organization)		\$
Each Occurrence		\$
Damage To Premises Rented To You (any one premise)		\$
Medical Expense (any one person)		\$
Errors and Omissions Coverage (Must be equal to GL limits, subject to \$1,000,000/\$3,000,000 maximum.)	Each Claim Aggregate	\$ #####
Other Coverages, Restrictions, and/or Endorsements:		\$
Deductible		\$

1. **Number of years in business:** \_\_\_\_\_
2. **Percentage of operations from sale of non-medical products, such as office furniture, printed materials (labels, charts, prescription forms), scales, etc.:**..... \_\_\_\_\_%

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

- Sale of Medical, Hospital and Surgical supplies ..... \$ \_\_\_\_\_
- Rental/leasing of home care products/equipment to consumers ..... \$ \_\_\_\_\_
- Rent-to-own of home care products/equipment to consumers ..... \$ \_\_\_\_\_
- Drugstore/Pharmacy ..... \$ \_\_\_\_\_
- Provider of in-home services ..... \$ \_\_\_\_\_

Describe: \_\_\_\_\_  
 \_\_\_\_\_

- Other ..... \$ \_\_\_\_\_

Describe: \_\_\_\_\_  
 \_\_\_\_\_

**4. Additional Insured Information:**

Name	Address

**5. 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.)			

**6. 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

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

**8. Any sale of vitamins or nutritional supplements under your own label?** .....  Yes  No

**9. Any sale or rental of oxygen and/or respiratory equipment, such as oxygen concentrators, cylinders and aspirators?** .....  Yes  No

If yes, percentage of total operation: ..... \_\_\_\_\_%

Any refilling of oxygen (or other gases)? .....  Yes  No

If yes, receipts: ..... \$ \_\_\_\_\_

10. **Any sale or rental of any other gases?** .....  Yes  No  
 If yes, describe: \_\_\_\_\_
- 
11. **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? \_\_\_\_\_
- 
12. **Do you do any construction or installation?** .....  Yes  No  
 If yes, explain: \_\_\_\_\_
- 
13. **Any vehicle chair lift installation, service or repair?** .....  Yes  No  
 If yes, receipts:..... \$ \_\_\_\_\_
14. **Any repair or installation operations subcontracted?** .....  Yes  No  
 If yes, do you obtain Hold Harmless Agreements from your subcontractors? .....  Yes  No  
 Minimum limits required of subcontractors:..... \$ \_\_\_\_\_
15. **Is equipment maintenance performed and documented according to manufacturers guidelines?**  Yes  No
16. **Are customers given any applicable Material Data Safety Sheets prepared by the equipment manufacturer?**.....  Yes  No
17. **What are your procedures for reporting any malfunctioning devices to the Federal Drug Administration?**  
 \_\_\_\_\_
- 
18. **Sale, rental or leasing of any of the following equipment or machines? Indicate by "x."**
- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Anesthesia apparatus              | <input type="checkbox"/> Intervenous                     | <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 and 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              |
| <input type="checkbox"/> Inhalation therapy machines       |  |  |
- If you sell latex gloves, who manufactures them? \_\_\_\_\_  
 Where is the latex gloves manufacturer located? \_\_\_\_\_  
 Are the latex gloves purchased from a U.S. based distributor? .....  Yes  No
19. **Do you directly import any foreign manufactured goods or equipment?** .....  Yes  No  
 If yes, provide details: \_\_\_\_\_
- 
20. **Do you manufacture any goods or equipment?**.....  Yes  No  
 Do you manufacture orthopedic, ambulation or prosthetic devices? .....  Yes  No  
 If yes, provide details: \_\_\_\_\_
-

21. 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: \_\_\_\_\_

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

23. 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.

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

25. Does risk engage in the generation of power, other than emergency back-up power, for their own use or sale to power companies? .....  Yes  No  
 If yes, describe: \_\_\_\_\_

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

27. During the past five years, have any claims been made or suits been brought against you because of alleged malpractice, error or mistake? .....  Yes  No  
 If yes, date: \_\_\_\_\_  
 Please explain: \_\_\_\_\_

28. 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: \_\_\_\_\_

29. Schedule Of Hazards:

Loc. No.	Classification Description	Class. Code	Exposure	Premium Bases (s) Gross Sales (p) Payroll (a) Area (c) Total Cost (t) Other

**30. Prior Carrier Information:**

	<b>Year:</b>	<b>Year:</b>	<b>Year:</b>	<b>Year:</b>	<b>Year:</b>
<b>Carrier</b>					
<b>Policy No.</b>					
<b>Coverage</b>					
<b>Occurrence or Claims Made</b>					
<b>Total Premium</b>					

**31. 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 five years.  Check if no losses last five years.

<b>Date of Loss</b>	<b>Description of Loss</b>	<b>Amount Paid</b>	<b>Amount Reserved</b>	<b>Claim Status (Open or Closed)</b>

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. **Not applicable in Nebraska, Oregon and Vermont.**

**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 policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant 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.

**WARNING TO DISTRICT OF COLUMBIA APPLICANTS:** 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 an application containing any false, incomplete, or misleading information is guilty of a felony in the third degree.

**NOTICE TO LOUISIANA 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.

**NOTICE TO MARYLAND APPLICANTS:** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and 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 MINNESOTA APPLICANTS:** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

**NOTICE TO OHIO APPLICANTS:** Any person who knowingly and with intent to defraud any insurance company 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 OKLAHOMA APPLICANTS:** 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.

**NOTICE TO RHODE ISLAND 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.

**FRAUD WARNING (APPLICABLE IN TENNESSEE, VIRGINIA 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.

Agent Name: \_\_\_\_\_

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

Email Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Please select your underwriter from the dropdown: