**MEDICAL EQUIPMENT SUPPLY STORES LIABILITY APPLICATION**

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

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| --- | --- |
| Applicant’s Name:    Mailing Address:    Location Address: | Agency Name:  Agent No.:  Address:    E-mail:  Phone No.: |

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

ANSWER ALL QUESTIONS—IF THEY DO NOT APPLY, INDICATE “NOT APPLICABLE” (N/A)

**Applicant is:**  Individual  Corporation  Partnership  Joint Venture

Limited Liability Company  Other (Specify):

**Website Address:**

**E-mail Address:**        **Phone No.:**

**Limits Of Liability and Deductible Requested:**

|  |  |
| --- | --- |
| General Aggregate (other than Products/Completed Operations) | $ |
| Products and Completed Operations Aggregate | $ |
| Personal and 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 Ommissions Coverage Each Claim (Must be equal to GL limits, subject to $1,000,000/$3,000,000 maximum.) 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 (e.g., 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:**

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| --- | --- | --- |
| **Name** | **Address** | **Interest** |
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**5. Provide breakdown of annual receipts:**

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| --- | --- | --- | --- |
|  | **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, stair chair lifts, pool lifts, 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 applicant’s 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

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| If yes, describe: |

**11. Does applicant buy or sell used equipment?**  Yes  No

Percentage of total operation:      %

If yes, does applicant recondition/repair, prior to resale?  Yes  No

Does applicant sell “as is”?  Yes  No

Does applicant deliver equipment?  Yes  No

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| If yes, how often? |

**12. Does applicant do any construction or installation?**  Yes  No

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| 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?**

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**18. Sale, rental or leasing of any of the following equipment or machines? Indicate by “x.”**

Anesthesia apparatus  Intravenous  Resuscitation equipment

Apnea monitors  Kidney machines  Scooters/Tricarts

Audiometers  Laser medical devices  Stair chair lifts

Beds, crutches, walkers, commodes  Latex gloves  Suction or Irrigation apparatus

Cardiac defibrillators  Low air loss mattress  TENS units

Diathermy machines  Metal and foreign body locators  Ventilators

Internal therapy  Nebulizers  Wheelchairs

EKG machines  Oscilloscopes and monitoring devices  Wheelchair lifts

Heart monitoring  Parenteral therapy  X-ray, fluoroscopy

Inhalation therapy machines  Radiation therapy

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. Does applicant directly import any foreign manufactured goods or equipment?**  Yes  No

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| If yes, provide details: |

**20. Does applicant manufacture any goods or equipment?**  Yes  No

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

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| If yes, provide details: |

**21. Does applicant employ or subcontract the services of any Respiratory Therapist or   
Physician?**  Yes  No

Do you employ any certified professionals?  Yes  No

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| If yes, explain: |

**22. Are you a member of any Health Industry Association?**  Yes  No

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| 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

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| If yes, describe: |

**26. Does applicant have any other business ventures for which coverage is not required?**  Yes  No

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| 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(s):

|  |
| --- |
| 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

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| If yes, explain: |

**29. Schedule Of Hazards:**

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| --- | --- | --- | --- | --- |
| **Loc. No.** | **Classification Description** | **Class.  Code** | **Exposure** | **Premium Basis** (s) Gross Sales (p) Payroll (a) Area (c) Total Cost  (t) Other |
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**30. Prior Carrier Information:**

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| --- | --- | --- | --- | --- | --- |
|  | **Year:** | **Year:** | **Year:** | **Year:** | **Year:** |
| **Carrier** |  |  |  |  |  |
| **Policy No.** |  |  |  |  |  |
| **Coverage** |  |  |  |  |  |
| **Occurrence or Claims Made** |  |  |  |  |  |
| **Total Premium** |  |  |  |  |  |

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.

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| **Date of  Loss** | **Description of Loss** | **Amount  Paid** | **Amount  Reserved** | **Claim Status  (Open or  Closed)** |
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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 AL, CO, DC, FL, KS, LA, ME, MD, MN, NE, NY, OH, OK, OR, RI, TN, VA, VT or WA.)

**FRAUD WARNING (APPLICABLE IN VERMONT, NEBRASKA AND OREGON):** Any person who intentionally presents a materially false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

**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.

I have read the above application and I declare that to the best of my knowledge and belief all of the foregoing statements are true, and that these statements are offered as an inducement to us to issue the policy for which I am applying. (Kansas: This does not constitute a warranty.)

APPLICANT’S SIGNATURE: DATE:

CO-APPLICANT’S SIGNATURE: DATE:

PRODUCER’S SIGNATURE: DATE:

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

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|  | **IMPORTANT NOTICE** |  |
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| 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. | | |