



Mid Valley General Agency LLC  
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## MEDICAL EQUIPMENT SUPPLY STORES LIABILITY APPLICATION

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

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 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 (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:**

Name	Address	Interest

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, 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  
 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  
 If yes, how often? \_\_\_\_\_
- 
12. Does applicant 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"/> Intravenous                          | <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"/> Laser medical devices                | <input type="checkbox"/> Stair chair lifts               |
| <input type="checkbox"/> Beds, crutches, walkers, commodes | <input type="checkbox"/> Latex gloves                         | <input type="checkbox"/> Suction or Irrigation apparatus |
| <input type="checkbox"/> Cardiac defibrillators            | <input type="checkbox"/> Low air loss mattress                | <input type="checkbox"/> TENS units                      |
| <input type="checkbox"/> Diathermy machines                | <input type="checkbox"/> Metal and foreign body locators      | <input type="checkbox"/> Ventilators                     |
| <input type="checkbox"/> Internal therapy                  | <input type="checkbox"/> Nebulizers                           | <input type="checkbox"/> Wheelchairs                     |
| <input type="checkbox"/> EKG machines                      | <input type="checkbox"/> Oscilloscopes and monitoring devices | <input type="checkbox"/> Wheelchair lifts                |
| <input type="checkbox"/> Heart monitoring                  | <input type="checkbox"/> Parenteral therapy                   | <input type="checkbox"/> X-ray, fluoroscopy              |
| <input type="checkbox"/> Inhalation therapy machines       | <input type="checkbox"/> 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

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

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

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

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

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. Does applicant have 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(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

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

**29. Schedule Of Hazards:**

Loc. No.	Classification Description	Class. Code	Exposure	<b>Premium Basis</b> (s) Gross Sales (p) Payroll (a) Area (c) Total Cost (t) Other

**30. Prior Carrier Information:**

	Year:	Year:	Year:	Year:	Year:
<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.

Date of Loss	Description of Loss	Amount Paid	Amount Reserved	Claim Status (Open or Closed)

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: \_\_\_\_\_

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.