

MEDICAL EQUIPMENT SUPPLY STORES APPLICATION

Applicant's Name	_____
Mailing Address	_____ _____ _____
Location:	_____
Complete a separate application for each location.	

Agent Name	_____
Address	_____ _____ _____

PROPOSED EFFECTIVE DATE:

From _____ To _____

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

- Applicant is:
- | | | | |
|--|--------------------------------------|--|--|
| <input type="checkbox"/> Individual | <input type="checkbox"/> Corporation | <input type="checkbox"/> Partnership | <input type="checkbox"/> Joint Venture |
| <input type="checkbox"/> Limited Liability Company | | <input type="checkbox"/> Other (Specify) _____ | |

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

- Full Named Insured** (If not shown above) _____
- Type of operation and annual sales:** _____
 - Sales of Medical, Hospital and Surgical supplies \$ _____
 - Rental/leasing of home care products/equipment to consumers \$ _____
 - Pharmacy \$ _____
 - Other—Describe: _____
- Are patrons fitted with rehabilitated 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
- Percentage of equipment sold or leased/rented which is physician prescribed: _____ %
- Percentage of operations from sale of non-medical products, such as office furniture, printed materials labels, charts, prescription forms), scales, etc. ? _____ %
- Sales 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 of 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?

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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?

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17. If a member of the Joint Commission on the Accreditation of Health Care Organization, are you Certified?
 Yes No
- Any other premises or operations exposure not stated in this application?..... Yes No**
If yes, attach a complete description and underwriting 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	Prem/ Ops	Products

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 past three years, has any company cancelled, declined, or refused similar insurance to the applicant/

Yes No

If yes, explain: _____

Previous Insurer: Indicate premium and losses for the 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 penalties.

NAME AND TITLE _____

APPLICANT'S SIGNATURE _____ DATE _____

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