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	Deductible	$	Total $

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".

_ Anesthesia apparatus	_ Inhalation therapy machines	_ Cardiac Defibrillators
_ X-ray, fluoroscopy	_ Resuscitation equipment	_ Radiation therapy
_ Kidney machines	_ Audiometers	_ EKG machines
_ Diathermy machines	_ Suction or Irrigation apparatus	_ Ventilators
_ Oscilloscopes	_ Metal & foreign body locators	_ 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.

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.

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 ______________

Name and Phone Number of individual to contact for inspection/audit ______________________________

Agent Name ______________________________ Agent License Number ______________

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