

Policy Effective Date: \_\_\_\_\_

**Account Information**

Insured's Name: \_\_\_\_\_  
 Mailing Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Contact Name: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Coastal State: Yes / No If yes, distance to body of water: \_\_\_\_\_ Number of Locations: \_\_\_\_\_  
 Do you have a WEBSITE? Yes / No If yes: \_\_\_\_\_  
 EMAIL ADDRESS: \_\_\_\_\_

**Description of Operations**

Corporation: Yes / No Type: \_\_\_\_\_ Individual: Yes / No  
 Provide a brief description of operations, including years in business: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

If new venture, provide years experience: \_\_\_\_\_  
 Any business conducted other than DME or O&P: Yes / No If yes, please describe: \_\_\_\_\_  
 \_\_\_\_\_

Current Carrier: \_\_\_\_\_ Premium: \_\_\_\_\_ Yrs with Carrier: \_\_\_\_\_

Prior Insurance Carrier and Policy Date: \_\_\_\_\_

Practitioner for Patient Care Certified: Yes / No

**Professional Liability**     Occurrence     Claims Made     Prior Acts Date \_\_\_\_\_  
 (Attach Copy of Prior Claims Made Policy Declarations if requesting Prior Acts.)

**General Liability**         Occurrence     Claims Made     Prior Acts Date \_\_\_\_\_  
 (Attach Copy of Prior Claims Made Policy Declarations if requesting Prior Acts.)

**General Information**

Member of any of the following? : (Please circle)    AOPA    AAHomecare    Pedorthic Footwear Assoc.  
 Other : \_\_\_\_\_

Is the Facility Accredited? : YES / NO

If yes, By Who and What Year? : \_\_\_\_\_

**General Questions**

Have you or anyone ever been convicted of fraud, arson or any other crimes related to a property loss in the last five years?    YES / NO

How close is the nearest fire department? \_\_\_\_\_ Miles

Are there any fire hydrants with-in 200 feet of the building?    YES / NO

Who has access to cash registers/safes? \_\_\_\_\_

Who has check writing authority? \_\_\_\_\_

Are pre-employment criminal background checks done? YES / NO        Run MVR's? YES / NO

Do you make daily deposits? YES / NO        Do you use an armed guard service? YES / NO

How many individuals work with accounts payable? \_\_\_\_\_

Do you require those working with accounts to take at least a weeks' vacation? YES / NO

Have you had any insurance losses or filed any claims in the past 3 years? YES / NO

If yes, please describe below:

<u>Description of Loss</u>	<u>Date of Loss</u>	<u>Amount Paid</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Please Indicate if you: Sell / Rent / Distribute /  
Repair Any of the Following Equipment**

*For Each Type, Please Check Box and Indicate Sales Amount*

<input type="checkbox"/> Monitoring Equipment	\$	<input type="checkbox"/> TENS Units	\$
Type of Equipment: (Please List)		<input type="checkbox"/> CPAP / BYPAP	\$
1)		<input type="checkbox"/> Halos / Cranial Helmets	\$
2)		<input type="checkbox"/> Buy / Sell / Repair Used Equipment (Please List)	\$
3)			
<input type="checkbox"/> Diagnostic Equipment (Please List)	\$	1)	
1)		2)	
2)		3)	
<input type="checkbox"/> Life Sustaining Equip. (Please List)	\$	<input type="checkbox"/> Devices that are implanted	\$
1)		<input type="checkbox"/> Vehicle Control Devices	\$
2)		<input type="checkbox"/> Hoists	\$
<input type="checkbox"/> Oxygen Support (Please List)	\$	<input type="checkbox"/> Wheelchairs/Cots/Gurneys	\$
1)		<input type="checkbox"/> Lifts	\$
2)		<input type="checkbox"/> Ramps	\$
<input type="checkbox"/> Respiratory Support	\$	<input type="checkbox"/> Grab Bars Do you Install? Years Experience Installing?	\$  YES / NO _____
<input type="checkbox"/> Respirators	\$		
<input type="checkbox"/> Hand Controls	\$		
<input type="checkbox"/> Other Auto Related Equip.	\$	<input type="checkbox"/> Pharmaceuticals, Drugs (Please List on Separate Page)	\$
<input type="checkbox"/> Surgical Equipment	\$		
<input type="checkbox"/> Installation of Stair Chairs	\$	<input type="checkbox"/> Installation of Patient Lifts	\$

If provider does installation of equipment, how many years of installation experience? \_\_\_\_\_

**Please Indicate Estimated Sales for Each Category :**

	<u>Last Year</u>	<u>Next Year</u>
<b><u>Practitioner Patient Care:</u></b> Includes all items you make, fit, alter, adjust for patients.	\$ _____	\$ _____
<b><u>Manufacturing:</u></b> Items manufactured by and sold to others to distribute. No patient care for this class.	\$ _____	\$ _____
<b><u>Wholesale Distribution:</u></b> Includes all items purchased from others that you resell to other facilities.	\$ _____	\$ _____
<b><u>Retail Customers (DME):</u></b> Include items that you rent/sell to others over the counter that you do not repackage, change, or modify.	\$ _____	\$ _____
<b><u>Medical Equipment:</u></b> Repair or Installation of any type of Medical Equipment.	\$ _____	\$ _____

Please provide a specific description for any "Checked" responses from the previous page. If available, please provide brochures with submission. \_\_\_\_\_

Do you re-package or re-label any items? YES / NO If yes, please explain: \_\_\_\_\_

Do you directly import any foreign products into the U.S.? YES / NO If yes, please list products \_\_\_\_\_

Do you require all vendors, manufacturers, distributors and any independent contractor to:  
Provide a Certificate of Insurance to show that the above carries and maintains coverage? YES / NO  
(Please provide copies of these certificates, if applicable.)

**Please Provide the Following Regarding Staff :**

# of Full Time Employees: _____	Part Time: _____	Independent Cont: _____		
<b>Position</b>	<b># Employed</b>	<b>Yrs. Employed</b>	<b>Ind. Cont.</b>	<b>Other</b>
Practitioner				
Respiratory Therapist				
Nurse				
Technician				
Physical Therapist				
Pharmacist				

**Pharmacy Exposure**

- Is there a pharmacy at any of the Business locations listed on this application? YES / NO
1. How many pharmacists are on staff? \_\_\_\_\_  
 a. Are they employees or independent contractors? \_\_\_\_\_
2. What are the names of the pharmacist(s)?  
 a. \_\_\_\_\_ c. \_\_\_\_\_  
 b. \_\_\_\_\_ d. \_\_\_\_\_
3. Does the pharmacist carry their own Pharmacist Professional Liability Policy? YES / NO  
 If yes, with whom and what are the policy limits? \_\_\_\_\_
4. Please confirm that only the licensed pharmacist re-labels, repackages, and/or compounds the pharmaceuticals. YES / NO

**Property Description / Locations :**

<u>FULL Location Address</u>	<u># of Stories</u>	<u>Construction / PC</u>	<u>Year Built</u>	<u>Sprinkler System</u>	<u>Sq. Feet</u>
1)					
2)					
3)					
4)					
5)					

*Note: If requesting building coverage and the building is over 30 years old, please provide information when the roof, plumbing, electrical & heating systems have been updated.*

If a coastal state, please indicate locations' roof type: \_\_\_\_\_

**Coverage :**

	<u>Location #1</u>	<u>Location #2</u>	<u>Location #3</u>	<u>Location #4</u>	<u>Location #5</u>
Building Value :					
Contents Value :					
Out Buildings (Garage, Sheds, etc.) :					

**\*\*Note:** Values should be 100% Replacement Cost. Unless otherwise requested or noted, all deductibles are \$500.

**Facility Safety**

- Central Station Alarm System for : Fire, Smoke, Break-in YES / NO Monitored 24 hours a day? YES / NO
- Are all stairs covered with anti-slip treads? : YES / NO
- Are handrails provided on all stairways? : YES / NO Hallways? : YES / NO
- Are parking lots free of debris and are surfaces smooth? : YES / NO
- Exterior of building well lit? : YES / NO
- Are the edges of curbs, sidewalks and steps color coded to identify raised surfaces? : YES / NO
- Who is responsible for the maintenance of building, such as snow/ice removal? : \_\_\_\_\_
- Please explain any "NO" responses : \_\_\_\_\_

**Facility Safety cont...**

Do you lease any part of the premises to another business or are there any other business activities, other than HME/DME, conducted on the premises that are not directly related to the coverage being requested on this application? If so, please explain \_\_\_\_\_

**Additional Insured** – Please list Names and Addresses Below and their Interest in your Operations.

<u>Name &amp; Address</u>	<u>Interest of Additional Insured</u>
1) _____	_____
2) _____	_____
3) _____	_____

**Would you like a quote for :**

Flood Insurance	YES / NO	Wind Insurance	YES / NO
Directors/Officers	YES / NO	Employment Practice Liab. Coverage	YES / NO

**Would you like an Umbrella to go over existing policy?** YES / NO

(Supplemental Application Required.) If yes, Limit desired \$ \_\_\_\_\_

If yes for Umbrella, please include the following:

Primary Auto Liab. Premium : _____	Carrier: _____
Work Comp Liab. Limits : _____	Carrier: _____

<u>Number of Auto(s)</u>	<u>Private Pass.</u>	<u>Trucks</u>	<u>Vans</u>

**Third Party Coverage**

- Total number of employees providing services for contracted clients: \_\_\_\_\_
- Total number of client contracts currently in place: \_\_\_\_\_
- Describe the services provided by your employees while on the premises of your contracted clients:  
\_\_\_\_\_
- Are any services performed for contracted clients off the clients' premises? If yes, please describe:  
\_\_\_\_\_
- Do you verify the employment background of prospective employees? \_\_\_\_\_
- Do you use non-employees to perform client services? If yes, how many? \_\_\_\_\_
- Describe supervisory procedures for all individuals engaged in performing contracted client services:  
\_\_\_\_\_

***Fraud Statement***

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any false information or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act which is a crime.

Date : \_\_\_\_\_ Applicants Signature : \_\_\_\_\_

