

HOME MEDICAL EQUIPMENT DEALERS APPLICATION

PLEASE CONTACT YOUR AGENT WITH ANY QUESTIONS AND TO RETURN COMPLETED APPLICATION

1. Named Insured (full name of all companies to be insured under this policy):

DBA: _____

Mailing Address: _____

Physical Loc #1: _____ SQ Feet _____

Physical Loc #2: _____ SQ Feet _____

Physical Loc #3: _____ SQ Feet _____

Attach a separate page if more than three locations

Contact Person: _____

Phone#: _____ Fax# _____ Company Website Address: _____

2. Type of business: Corporation Individual Partnership Other (explain) _____

3. How many years experience in field? _____ How many years operating under same ownership? _____

(NEW ventures, please provide copy of resume/experience in the medical industry.)

4. Name(s) of all current owner(s) and percentage owned by each: _____

****NOTE: Your insurance company must be notified of any changes in ownership at the time the ownership changes are made. Insurance coverage is not transferable.**

5. Have you ever carried insurance that was written on a "claims made" basis? Yes No
If yes — Retro Date: _____ (Provide copy of Dec Page)

6. Effective date requested _____

7. Limit of Liability: \$300,000/\$300,000 \$500,000/\$500,000
 \$1,000,000/\$1,000,000 \$1,000,000/\$2,000,000 \$1,000,000/\$3,000,000
 \$2,000,000/\$2,000,000 \$2,000,000/\$3,000,000 \$2,000,000/\$4,000,000
 \$3,000,000/\$3,000,000

8. Estimated Gross Revenue for the **next 12 months**:

Sales Revenue: \$ _____ Rental Revenue: \$ _____

Repair/Service Revenue: \$ _____ TOTAL: \$ _____

Actual Gross Revenue for the **past 12 months**: \$ _____

9. Please provide a % breakout of who you are selling/renting equipment to. **TOTAL %'s MUST EQUAL 100%.**

Patient for home use: _____% Nursing homes: _____% Assisted living facilities: _____%
 Doctors offices: _____% Hospitals: _____% Other: _____% (explain) **Total:** _____%

10. Inventory (products handled) is based on your Gross Revenue in percentages. Gross Revenue percentages must equal 100%.

Oxygen Concentrators	_____%	Sell Grab Bars	_____%	Apnea Monitors	_____%
Oxygen Cylinders	_____%	Install Grab Bars	_____%		
Liquid Oxygen	_____%			Beds, Crutches, Walkers, Commodes	_____%
Oxygen Valves/Reg	_____%	Stair Lifts		Braces	_____%
		<input type="checkbox"/> Commercial *	_____%	CPAP/BiPAP	_____%
Manual Wheelchairs	_____%	<input type="checkbox"/> Residential	_____%	CPM	_____%
Motor Wheelchairs	_____%			Disposable	_____%
Scooter/Tri-Carts	_____%	Wheelchair Lifts		Enteral Therapy	_____%
		<input type="checkbox"/> In the Home	_____%	Low Air Loss Mattress	_____%
Auto Conversions *	_____%	<input type="checkbox"/> In Autos *	_____%	Nebulizers	_____%
Diabetic Shoes	_____%			Parenteral Therapy	_____%
Pharmacy *	_____%			Tens Units	_____%
Sleep Study Testing *	_____%			Ventilators	_____%

Please list any other items sold or rented below, along with a corresponding percentage for each item:

_____	_____%	_____	_____%	_____	_____%
_____	_____%	_____	_____%	_____	_____%

Total of All Three Columns _____%
(TOTAL MUST = 100%)

*** If commercial stair lifts, automobile conversions, wheelchair lifts "in autos," pharmacy or sleep studies, please complete appropriate supplemental application.**

11. If selling diabetic shoes, please answer the following questions:

- a. Are the shoes sold with a doctor's prescription? Yes No
- b. Is there an orthotist or pedorthist on staff? Yes No
 If yes, does the orthotist or pedorthist carry his/her own professional liability coverage? Yes No
 If yes, what limits of liability does their policy carry? _____
- c. What percentage, if any, are off-the-shelf items, such as braces, inserts, arches, etc.? _____
- d. Do you measure the patient's foot to determine shoe size needed or is that done by the doctor?
 Measured by you Measured by doctor
- e. If measured by you, what is the process for measuring? (Measuring stick, foot mold, etc.)?

12. Do you obtain an Additional Insured – Vendor Endorsement from your manufacturers naming you as the additional insured? Yes No

13. Are you accredited by JCAHO? Yes No

14. Do you have a formal risk management procedure in place? Yes No

15. Do you provide continuing education to your employees? Yes No

16. Do you service or repair any HME products other than those that you have sold/rented? Yes No
 If yes, what items? _____
 What % of your gross revenue is service work on equipment other than what you have sold/rented? _____
 Do you provide any type of warranty on your service/repair work? Yes No
 If yes, explain: _____
17. How many independent contractors (1099s) do you use for your HME business? _____
 If yes, what are you using them for? _____
 Do you want them added to your policy as Additional Insured? Yes No
 If yes, please provide the name and address of each individual (ATTACH SEPARATE SHEET).
18. Do you contract or subcontract labor for installation, service or repair of any products? Yes No
 If yes, what products? _____
 Do you provide any type of warranty for contracted or subcontracted labor? Yes No
 If yes, please explain _____
19. Do you install any equipment (involving the use of tools of any kind) in customer homes? Yes No
 If yes, what equipment are you installing? _____
 Do you provide any type of warranty for installations? Yes No
 If yes, please explain _____
20. Do you perform sleep studies? (If yes, please complete supplemental application.) Yes No
21. Do you want a quote for Non-Owned Auto Liability? (If yes, complete supplemental.) Yes No
22. Do you want a quote for Hired Auto Liability? (If yes, complete supplemental.) Yes No
23. Have you had any known Products/Professional or General Liability losses in the last five years? Yes No
 If yes, please provide details of claim(s) including date of loss and dollar amount of loss (attach separate sheet if necessary): _____

PLEASE NOTE THAT CURRENTLY VALUED LOSS RUNS FOR THE LAST FIVE YEARS ARE REQUIRED TO BIND COVERAGE

Please list all carrier information for the last four years.

Carrier Name _____ Policy Term: _____ Premium: _____

Carrier Name _____ Policy Term: _____ Premium: _____

Carrier Name _____ Policy Term: _____ Premium: _____

Carrier Name _____ Policy Term: _____ Premium: _____

24. Do you employ any certified professionals? Yes No
 If yes, do they or you carry professional liability coverage? Yes No
 Please state number of certified professionals by category:
 Respiratory therapists _____ Nurses _____ Other, please describe _____

Describe their duties: _____

25. Are you certified by Medicare/Medicaid? Yes No
 Do you bill Medicare/Medicaid? Yes No
 If YES, would you like someone to contact you regarding a quote for a surety bond? Yes No

Policies are minimum earned premium and subject to audit for purposes of determining additional premiums only.

The warranties following will be made a part of any policy issued under this program.

WARRANTED: The company named on the front hereof and as signed below does not engage in any of the following activities:

- A. Manufacture of any product.
- B. Re-manufacture or re-building of any item (repairs allowed — see below).
- C. Provide home health nursing, therapy or other medical or quasi-medical in nature services of any kind.
- D. Charge a fee for medical related services.
- E. Directly import any product.

WARRANTED: The company named on the front hereof and as named below will adhere to the following quality criteria to be eligible for (and remain eligible for) coverage under this insurance program:

- A. Repair work allowed on equipment owned, rented or sold, by trained personnel and following manufacturer recommendations. No significant outside repair work is allowed.
- B. If oxygen is offered, a true 24-hour service program must exist.
- C. Insured must have and designate a “safety manager” to receive, catalog and disseminate all safety and loss control information.
- D. No injections or IV administration may be done by an insured unless the individual so doing is properly licensed and the administration is incidental to the sale or rental of the equipment and not on a fee basis.
- E. Van conversion must be disclosed and specifically approved by Insurer.

WARNING! This is an important document, which could affect your legal rights. Please **read it again carefully** and **be certain it is correct and complete**. Your signature below is your warranty to us that we can rely on this form. We have made no investigation of our own and the coverage decision will be based on this information. **COVERAGE IS NOT BOUND OR STARTED BY THIS FORM. WE MAKE NO PROMISE TO INSURE. THIS IS ONLY A REQUEST FOR A QUOTE. YOU ARE NOT COVERED UNTIL AND UNLESS YOU RECEIVE A BINDER SO STATING.**

The coverage that we are quoting from information on this form are Product/Completed Operations & Professional and/or General Liability Insurance. We base important decisions on your answers to these questions. If your answers are not correct or complete we could make a mistake and include people in the program who do not qualify or decline to offer coverage to those who do. We rely on the accuracy of your answers. If you have any questions about the form or your answers, please ask before completing the form.

The questions in this application are not intended to, nor do they, indicate the existence, non-existence or limitations on any items of coverage. This document does not in any fashion determine the coverage provided.

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.

YOUR APPLICATION CANNOT BE PROCESSED UNLESS COMPLETED IN ITS ENTIRETY.

Signature of Applicant	Date	Name and Title
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(Must be signed by principal, partner or officer of group or individual applying for insurance.)