DURABLE MEDICAL EQUIPMENT SALES AND SERVICES PROFESSIONAL AND GENERAL LIABILITY INSURANCE APPLICATION
CLAIMS MADE AND REPORTED BASIS

Desired effective date: _____

1. Complete name of applicant (if other than parent firm, supply full details of ownership entity; attach an additional sheet if necessary):

   _____

   Address: _____

   City: _____ State: _____ County: _____ ZIP: _____

   Contact Name: _____ Title: _____

   Contact Email Address: _____ Phone: _____

   Website URL: _____

   List all other locations:

2. Applicant is:
   a. ☐ Individual ☐ Partnership ☐ Corporation ☐ Professional Association ☐ Other: _____
   b. ☐ Not-for-Profit ☐ For-Profit ☐ Both
3. Date established: _____
4. Are you requested to be licensed? ☐ Yes ☐ No
5. Has the applicant's state license, registration or certification, or certification for federal reimbursement ever been limited, revoked, suspended, refused, cancelled or voluntarily surrendered? ☐ Yes ☐ No

   If yes, provide details:

6. Current accreditations or associations: ☐ NAHC ☐ TAHC ☐ JCAHO ☐ CHAP ☐ NHPCO ☐ Other: _____
7. Is the firm engaged in, owned by or associated with or controlled by any other business? ☐ Yes ☐ No

   If yes, provide details:

8. Please list the individual shareholders or partners of the facility:
9. Does the applicant or any partner, owner or director own (wholly or in part), operate or administer any hospital, nursing home or other institution in which medical services are customarily rendered? ☐ Yes ☐ No

   If yes, provide details:

10. Are any services provided outside of the United States? ☐ Yes ☐ No

    If yes, please explain, including what countries, what type of services are provided and what percentage of your revenues are derived from these services:

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11. Do you provide any internet services? ☐ Yes ☐ No
    If yes, please attach an explanation, including confirmation of licensing in all states in which services are provided.
12. Does the applicant advertise its professional services in any manner (other than a simple listing in a telephone directory? ☐ Yes ☐ No
    If yes, please attach copies of **all** advertisements.
13. Does the applicant participate in any activity, e.g. newspaper columns, broadcasts, etc., whereby professional advise is offered to the public?
    ☐ Yes ☐ No
14. Hold Harmless (Indemnification) Agreements:
    a. **In favor of the applicant:** If the applicant has obtained any written indemnification agreements holding the applicant harmless, please describe and indicate if certificates of insurance are obtained:

    b. **In favor of others:** Has the applicant agreed to indemnity (hold harmless) others under written contract? ☐ Yes ☐ No
    If yes, please submit a copy of the agreement.
15. Is the applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPPA) Privacy Rule? ☐ Yes ☐ No
    If yes,
    a. Has the Applicant implemented procedures to comply with the HIPPA Privacy Rule? ☐ Yes ☐ No
    b. Name and title of the applicant's Privacy Officer: _____

OPERATIONS

1. Does the applicant or any of its employees or independent contractors provide services for correctional facilities such as a prisons, detention centers, jails, etc.? ☐ Yes ☐ No
2. Percentage of sales to the public: _____ % Percentage of sales to institutions: _____ %

    a. **EXPENDABLE ITEMS:** Intended for one-time use, such as adhesive tape, bandages, hypodermic needles, etc.
    Estimated receipts in the next 12 months: $ _____
    Actual receipts in the last 12 months: $ _____

    Any pharmaceutical product sales? ☐ Yes ☐ No
    If yes, what percentage of the above receipts will be pharmaceutical for the next 12 months? _____ %

    b. **NON-EXPENDABLE ITEMS:** Excludes diagnostic or treatment equipment or devices. Including but not limited to hospital beds, bathroom safety bars, patient lifts or hoists, walkers, stroller, canes, crutches or wheelchairs, etc.
    Estimated receipts in the next 12 months: $ _____
    Actual receipts in the last 12 months: $ _____

    Do you lease or rent any of the above equipment? ☐ Yes ☐ No
    If yes, what percentage of the above receipts are leased or rented? _____ %

    c. **DIAGNOSTIC OR TREATMENT DEVICES:** Includes oxygen and other medical gases used in conjunction with respiratory therapy, **excluding** ventilators, treatment devices or equipment **not** used to sustain life or perform critical life monitoring functions. Includes blood pressure gauges, IV pumps, portable EKG machines or sending devices.

    Estimated receipts in the next 12 months: $ _____
    Actual receipts in the last 12 months: $ _____

    Do you lease or rent any of the above equipment? ☐ Yes ☐ No
    If yes, what percentage of the above receipts are leased or rented? _____ %

d. **LIFE SUSTAINING OR CRITICAL LIFE MONITORING EQUIPMENT OR DEVICES**: Includes dialysis or heart/lung machines, apnea monitors, SIDS monitors or any other life dependent monitors, equipment or devices that the malfunction/failure or Improper function of which could result in death or serious deterioration in health condition.

Estimated receipts in the next 12 months: $ _____

Actual receipts in the last 12 months: $ _____

Do you lease or rent any of the above equipment? ☐ Yes ☐ No

If yes, what percentage of the above receipts are leased or rented? _____ %

3. Have any of the products you distribute ever been recalled? ☐ Yes ☐ No

If yes, please explain:

4. Is the applicant an additional insured vendor on the manufacturer's policy for all products? ☐ Yes ☐ No
5. Does the applicant's employees or independent contractors:
   a. Have written instructions for the use of the products provided to the user? ☐ Yes ☐ No

   If yes, are the written instructions reviewed with and required to be signed of by the user? ☐ Yes ☐ No
   b. Do you modify any products in any way after their original manufacture? ☐ Yes ☐ No

   If yes, please explain:
   c. Do you repackage ore re-label any items obtained from suppliers? ☐ Yes ☐ No

   If yes, please explain:
   d. Is any equipment sold with the applicant's label? ☐ Yes ☐ No

   If yes, please explain:
   e. Do you maintain a written quality control program? ☐ Yes ☐ No
   f. Do you have your own sales staff? ☐ Yes ☐ No
   g. Are all devices and/or equipment checked and their condition documented prior to their release? ☐ Yes ☐ No
   h. Is preventive maintenance performed on al equipment and devices according to a written schedule? ☐ Yes ☐ No
   i. Do you repair or sell other people's used equipment? ☐ Yes ☐ No
   j. Are serial numbers of the finished product shown on shipment invoices and complete records kept of inventory shipments? ☐ Yes ☐ No
   k. Do you use the services of an EPA approved contractor to dispose of hazardous waste materials? ☐ Yes ☐ No
   l. Do you distribute oxygen cylinders? ☐ Yes ☐ No
6. Does the applicant use a collection agency? ☐ Yes ☐ No

   If yes:
   a. Name of agency: _____
   b. Does the agency have authority to file a collection suit on behalf of the applicant? ☐ Yes ☐ No
7. Does the applicant have a written safety program in place? ☐ Yes ☐ No

   If yes, attach a copy of the written safety program.
8. Does the applicant have written procedures for incident reporting? ☐ Yes ☐ No

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9. Do any of the applicant's locations have any:
   a. Exposure to flammables, explosive, chemicals? ☐ Yes ☐ No
   b. Catastrophe exposure? ☐ Yes ☐ No
   c. Exposure to radioactive materials? ☐ Yes ☐ No
10. Do any of the applicant's operations involve storing, treating, discharging, applying, disposing of, or transporting hazardous materials?
    ☐ Yes ☐ No

EXISTING INSURANCE

Do you currently carry the following:

1. Professional Liability Insurance? ☐ Yes ☐ No

   If yes, list the Professional Liability Insurance carried by the firm for each of the past five years including periods of no coverage:

Policy Period **FROM** MM/DD/YY	Policy Period **TO** MM/DD/YY	Insurance Company	Limit of Liability	Deductible	Policy Form: Claims Made **OR** Occurrence?	Premium
			$	$		$
			$	$		$
			$	$		$
			$	$		$
			$	$		$

   If claims made, what is the retroactive date/prior acts date on your current policy? _____

2. Commercial General Liability Insurance? ☐ Yes ☐ No

   If yes, list the Commercial General Liability Insurance currently carried by the firm:

Policy Period	Carrier	Limit of Liability BI/PD	Deductible	Policy Form: Claims Made **OR** Occurrence?	Premium
		$	$		$

   If claims made, what is the retroactive date/prior acts date on your current policy? _____

HISTORY

1. Has the applicant or any of its employees ever:
   a. Been the subject of disciplinary or investigatory proceedings or reprimand by a licensing, administrative or governmental agency?
      ☐ Yes ☐ No
   b. Been convicted for an act committed in violation of any law or ordinance including traffic offenses? ☐ Yes ☐ No
   c. Been evaluated or treated for alcoholism or drug addiction or mental or mental or emotional disorders? ☐ Yes ☐ No

      If yes, provide details:

d. Had any professional license or license to prescribe or dispense narcotics been denied, limited, refused, suspended, revoked, renewal refused or accepted only on special terms or has the applicant or any of its employees voluntarily surrendered any professional license?
☐ Yes ☐ No
If yes, provide details:

2. Has any insurer cancelled, rescinded, nonrenewed or declined any similar insurance for the applicant, its predecessors, subsidiaries, affiliates, employees and/or for any other person or entity proposed for his insurance in the last five years? ☐ Yes ☐ No
If yes, attach a copy of such insurer's notice.

CLAIMS HISTORY

1. During the past five (5) years, have there been any professional or general liability claims or incidents made against you, any employee or former employee, the applicant or anyone proposed for this insurance? ☐ Yes ☐ No

ATTACH CURRENTLY VALUED COMPANY LOSS RUNS FOR THE PRIOR FIVE (5) YEARS.
IF NO PRIOR COVERAGE, COMPLETE CLAIM SUPPLEMENT.

2. Are you, or anyone proposed for this insurance aware of any fact(s), incident(s), act(s), event(s), circumstance(s) or occurrence(s) that may result in a claim(s) being made against you? ☐ Yes ☐ No
If yes, provide full details:

3. Have there been any prior complaints or incidents reported arising out of alleged or actual physical or sexual abuse or molestation?
☐ Yes ☐ No
If yes, fully describe the circumstances and follow-up action taken:

APPLICANT SIGNATURE PANEL

THE APPLICANT DECLARES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE INCEPTION DATE OF THE POLICY PERIOD, WILL IMMEDIATELY NOTIFY THE UNDERWRITERS OF SUCH CHANGE. SIGNING OF THIS APPLICATION DOES NOT BIND THE UNDERWRITERS TO OFFER, NOR THE APPLICANT TO ACCEPT INSURANCE; BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE INSURANCE AND MADE A PART OF THE POLICY 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 CONTAINING 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.

Notice applicable in most states: 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 material fact, commits a fraudulent insurance act, which is a crime and may also be subject to civil penalty.

I/We hereby declare that the above statements and particulars are true and I/we agree that this application shall be the basis of the contract with the insurance company.

Authorized signature _____ Date _____

Typed or printed name: _____ Title: _____

