

**APPLICATION FOR DURABLE MEDICAL EQUIPMENT SALES AND SERVICES
PROFESSIONAL AND GENERAL LIABILITY INSURANCE**

(CLAIMS MADE AND REPORTED BASIS)

Please email this application back to the underwriter with whom you are working.
For contact information please visit www.usrisk.com/healthcare.html

I. GENERAL INFORMATION:

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

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Contact name: _____ Title: _____ Email address: _____

Phone: _____ Web site Address: _____ Fax: _____

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, give details (use an additional sheet of paper if necessary): _____

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 where medical services are customarily rendered? Yes No
If yes, give 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: _____

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 a copy of ALL of the advertisements.

13. Does the applicant participate in any activity, e.g. newspaper columns, broadcasts, etc., whereby professional advice 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 indemnify (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 (HIPAA) Privacy Rule? Yes No
 If yes,
 (a) Has the Applicant implemented procedures to comply with the HIPAA Privacy Rule? Yes No
 (b) Provide the name and title of the Applicant's Privacy Officer. _____

II. OPERATIONS:

1. Does the Applicant or any of its employees or independent contractors provide services for correctional facilities, such as a jail, detention center, prison, etc.? Yes No

2. Percentage of sales to the public: _____ % Percentage of sales to institutions: _____ %

Expendable items: Intended for one time usage (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? _____ %

Non Expendable items: Excluding diagnostic or treatment equipment or devices. Includes, 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? _____ %

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? _____ %

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?

III. OPERATIONS:

1. Have any of the products you distribute ever been recalled? Yes No
If Yes, please explain. _____
2. Is the applicant an Additional Insured Vendor on the manufacturer's policy for all products? Yes No
3. 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, 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 preventative maintenance performed on al equipment & 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
4. 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
5. Does the Applicant have a written safety program in place? Yes No
If Yes, attach a copy of the written safety program.
6. Does the Applicant have written procedures for incident reporting? Yes No
7. 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
8. Do any of the Applicant's operations involve storing, treating, discharging, applying, disposing, or transporting hazardous materials? Yes No

IV. INSURANCE INFORMATION:

1. Do you currently carry the following:
 - (a) Professional Liability Insurance? Yes No

List the Professional Liability Insurance carried by the firm for each of the past **five** years including periods of no coverage.

Policy Period		Insurance Company	Limit of Liability	Deductible	Policy Form: Claims Made or Occurrence?	Premium
From: MM/DD/YY	To: MM/DD/YY					
/ /	/ /					
/ /	/ /					
/ /	/ /					
/ /	/ /					
/ /	/ /					

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

(b) **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? _____

V. HISTORY:

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

VI. CLAIMS HISTORY:

- 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 ATTACHED CLAIM SUPPLEMENT**

- 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. _____
- 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: _____

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.

