

U.S. Risk, LLC | 14241 Dallas Parkway, Suite 850, Dallas, Texas 75254

**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:**

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

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 <b>OR</b> 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 <b>OR</b> 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: \_\_\_\_\_