

## Application For Medical Equipment (DME) Sales/Rental/Lease Liability

- Western World Insurance Company  
 Tudor Insurance Company

1. Name of Applicant \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Applicant's Web Site Address \_\_\_\_\_

2. Date Established \_\_\_\_\_ and Type of Organization  Individual  Partnership  Corporation  
 Other (Please explain.) \_\_\_\_\_

3. Please provide full names of individuals or partners and their interests: *(If needed, continue on Attachment to A17.)*  
 Name \_\_\_\_\_ Interest \_\_\_\_\_  
 Name \_\_\_\_\_ Interest \_\_\_\_\_  
 Location of premises/operations.  Check if SAME as above.  
 Street Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

4. Please provide the following information.  Check if no prior insurance.

Insurance Company	Policy Period	Limits of Liability	Premium	Type of Coverage Occurrence or Claims Made

5. During the past **three (3) years**, have any claims been presented to your current or prior insurance carrier(s)? *(If yes, please provide description of claim(s), date of loss, amount(s) paid and reserved on Attachment to A17.)*  Yes  No

6. Is the applicant, or any other person for whom insurance is being requested, aware of any circumstances which may result in a claim? *(If yes, please provide full details on Attachment to A17.)*  Yes  No

7. **Professional Liability Information** – If applicant uses certified professionals, please state number by category.

	Employed	Contracted
Therapists	_____	_____
Nurses	_____	_____
Orthotist	_____	_____
Prosthetist	_____	_____
Other	_____	_____
Description _____		

- Does applicant always verify licensing/certification?  Yes  No  
 Do certified professionals carry own General Liability insurance?  Yes  No  
 Do certified professionals carry own Professional Liability insurance?  Yes  No  
 Does applicant require annual Certificates of Insurance?  Yes  No

What limits do certified professionals carry? \$ \_\_\_\_\_

8. Show separate gross sales for items sold. \$ \_\_\_\_\_  
 Show separate gross sales for items rented/leased. \$ \_\_\_\_\_  
 Total estimated gross sales for the upcoming year. \$ \_\_\_\_\_  
 Show payroll for service or repair by employees. \$ \_\_\_\_\_  
 Show cost for installation and repair work subcontracted. \$ \_\_\_\_\_  
 Show sales of re-conditioned or used equipment \$ \_\_\_\_\_  
 Show sales of reprocessed medical equipment or devices \$ \_\_\_\_\_

9. **Product Information** – Check-off items being sold, rented or leased.

	<b>Do you carry?</b>	<b>Rent or Sales</b>	<b>Do you install?</b>
Apnea Monitors	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Rent <input type="checkbox"/> Sales	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arterial Pressure Monitors	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Rent <input type="checkbox"/> Sales	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anesthesia Equipment	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Rent <input type="checkbox"/> Sales	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Gas Analyzing Equipment	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Rent <input type="checkbox"/> Sales	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bi-Paps/V-Paps	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Rent <input type="checkbox"/> Sales	<input type="checkbox"/> Yes <input type="checkbox"/> No
C-Paps	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Rent <input type="checkbox"/> Sales	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cardiac Output Machine	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Rent <input type="checkbox"/> Sales	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetic Equipment ( <i>Please attach list.</i> )	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Rent <input type="checkbox"/> Sales	<input type="checkbox"/> Yes <input type="checkbox"/> No
Defibrillators	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Rent <input type="checkbox"/> Sales	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dialysis Equipment	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Rent <input type="checkbox"/> Sales	<input type="checkbox"/> Yes <input type="checkbox"/> No
Durable Medical Equipment	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Rent <input type="checkbox"/> Sales	<input type="checkbox"/> Yes <input type="checkbox"/> No
Expendable Medical Supplies	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Sales	N/A
Grab Bars	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Rent <input type="checkbox"/> Sales	<input type="checkbox"/> Yes <input type="checkbox"/> No
IPPB ( <i>Intermittent Positive Pressure Breathing</i> )	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Rent <input type="checkbox"/> Sales	<input type="checkbox"/> Yes <input type="checkbox"/> No
Infusion Therapy Equipment	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Rent <input type="checkbox"/> Sales	<input type="checkbox"/> Yes <input type="checkbox"/> No

*If yes, please list:* \_\_\_\_\_

Infusion Therapy Services Provided  Yes  No

*If yes, please list:* \_\_\_\_\_

*If yes, where done?*  Patient's Home  Hospital  Nursing Home/Assisted Living

Intensive Care Incubators	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Rent <input type="checkbox"/> Sales	<input type="checkbox"/> Yes <input type="checkbox"/> No
Laser Equipment	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Rent <input type="checkbox"/> Sales	<input type="checkbox"/> Yes <input type="checkbox"/> No
Life Function Monitoring	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Rent <input type="checkbox"/> Sales	<input type="checkbox"/> Yes <input type="checkbox"/> No
Medical Gas Piping System	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Rent <input type="checkbox"/> Sales	<input type="checkbox"/> Yes <input type="checkbox"/> No
Operating Room Equipment	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Rent <input type="checkbox"/> Sales	<input type="checkbox"/> Yes <input type="checkbox"/> No
Oxygen Equipment	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Rent <input type="checkbox"/> Sales	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>Sub-contracted?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Does applicant follow standard suppliers procedures?</i>		<input type="checkbox"/> Yes <input type="checkbox"/> No
Pace Makers	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Rent <input type="checkbox"/> Sales	<input type="checkbox"/> Yes <input type="checkbox"/> No
Resuscitators	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Rent <input type="checkbox"/> Sales	<input type="checkbox"/> Yes <input type="checkbox"/> No
Small Volume Nebulizers	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Rent <input type="checkbox"/> Sales	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stair Lifts	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Rent <input type="checkbox"/> Sales	<input type="checkbox"/> Yes <input type="checkbox"/> No
Transcutaneous Nerve Stimulators	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Rent <input type="checkbox"/> Sales	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ventilators – Life Support	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Rent <input type="checkbox"/> Sales	<input type="checkbox"/> Yes <input type="checkbox"/> No
Vertical (Hoyer) Lifts	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Rent <input type="checkbox"/> Sales	<input type="checkbox"/> Yes <input type="checkbox"/> No
Wheel Chairs – Standard	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Rent <input type="checkbox"/> Sales	<input type="checkbox"/> Yes <input type="checkbox"/> No
Wheel Chairs – Power	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Rent <input type="checkbox"/> Sales	<input type="checkbox"/> Yes <input type="checkbox"/> No
Wheel Chairs – Lifts	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Rent <input type="checkbox"/> Sales	<input type="checkbox"/> Yes <input type="checkbox"/> No
Motorized/Electrical Scooters	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Rent <input type="checkbox"/> Sales	<input type="checkbox"/> Yes <input type="checkbox"/> No
X-Ray Equipment	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Rent <input type="checkbox"/> Sales	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other ( <i>Specify – please attach listing.</i> )	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Rent <input type="checkbox"/> Sales	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Chemotherapy**

**Licensed/Certified**

**Employed**

**Sub-Contractor<sup>(1)</sup>**

Prepare Drugs  Yes  No

Yes\*  No

Yes  No

Yes  No

*\* If yes, please explain License/Certification* \_\_\_\_\_

Administer Drugs  Yes  No

Yes\*  No

Yes  No

Yes  No

*\* If yes, please explain License/Certification* \_\_\_\_\_

Training for Use of Equipment  Yes  No

Yes  No

Yes  No

Yes  No

<sup>(1)</sup>*If sub-contracted, are Certificates of Insurance required?*  Yes  No

**Closed Pharmacy (ONLY)** – Not open to the general public; please list all compounds prepared.

(A) \_\_\_\_\_ (B) \_\_\_\_\_ (C) \_\_\_\_\_

10. Do manufacturers name you as Vendor/Additional Insured?

Yes  No

*(If yes, please attach Certificate of Insurance.)*

11. What foreign-made products are sold? (Specify – attach listing.)
12. Any sales of used equipment?  Yes  No Gross sales: \$ \_\_\_\_\_
13. Describe any sales outside the U.S. on Attachment to A17. Gross sales: \$ \_\_\_\_\_
14. Please provide the following information.

Additional Insureds	Interests	Certificate of Insurance Required?
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No

15. LIMITS OF INSURANCE REQUESTED:

- General Aggregate Limit (Other Than Products – Completed Operations) \$ \_\_\_\_\_
- Products – Completed Operations Aggregate Limit \$ \_\_\_\_\_
- Personal and Advertising Injury Limit \$ \_\_\_\_\_
- Each Occurrence Limit \$ \_\_\_\_\_
- Damage to Premises Rented by You (Up To \$100,000 Limit Available) \$ \_\_\_\_\_ Any One (1) Premises
- Medical Expense Limit (Up To \$5,000 Limit Available) \$ \_\_\_\_\_ Any One (1) Person
- Each Professional Incident Limit (If Applicable) \$ \_\_\_\_\_

**FOR SEXUAL MOLESTATION COVERAGE , PLEASE COMPLETE QUESTIONS 16 THROUGH 20.**

\$25,000/50,000 limit is included **if there is Professional Coverage** at no additional charge. Higher limits are available for an additional premium charge(see below). If sexual molestation coverage for Professionals is not desired, please check here  Coverage is NOT requested.

16. Has your facility had any incidents or claims brought against it for sexual molestation or any other allegation of misconduct?  Yes  No  
Please provide details \_\_\_\_\_

17. Has any facility that you have been associated with in the past ever had any incidents occur or claims brought against it while you were there?  Yes  No  
Describe \_\_\_\_\_

18. Does your facility do background checks on all employees and volunteers?  Yes  No  
Describe type of checks performed (prior employer, police, etc.) \_\_\_\_\_

19. Are there written guidelines in place regarding sexual misconduct?  Yes  No  
If NO, please explain \_\_\_\_\_

20. Please check the limits you are requesting:  \$25,000/50,000 - included  
 \$50,000/100,000  \$100,000/300,000  300,000/600,000  \$500,000/1MM  \$1MM/2MM

21. Premises Exposure:

Building \_\_\_\_\_ ACV/RC \_\_\_\_\_ Co. Ins. \_\_\_\_\_

Contents \_\_\_\_\_ ACV/RC \_\_\_\_\_ Co. Ins. \_\_\_\_\_

Business Income \_\_\_\_\_ EE \_\_\_\_\_

Construction of Building? \_\_\_\_\_ # of Floors? \_\_\_\_\_ Age of Building? \_\_\_\_\_

Sprinklered?  Yes  No Alarmed?  Yes  No

Protection Class 1-8 \_\_\_\_\_ Protection Class 9&10 \_\_\_\_\_ Area (Sq. Ft.) \_\_\_\_\_

