ORTHOTIC & PROSTHETIC PROVIDERS
PLEASE CONTACT YOUR AGENT WITH ANY QUESTIONS AND TO RETURN COMPLETED APPLICATION

1. Full Named Insured (Include all Legal Names and DBA's)

_____

_____

Mailing Address: _____

Physical Loc #1: _____

Physical Loc #2: _____

Physical Loc #3: _____

Attach a separate page if more than 3 locations

Contact Person**:** _____ Effective date Requested _____

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? _____

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 transferrable.**

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. Gross Revenue This Fiscal Year

$_____

Gross Revenue Next Fiscal Year

$_____

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
☐ $3,000,000/$3,000,000
☐ $3,000,000/$5,000,000

8. **Please specify type of business:**

Are you a Manufacturer of Orthotics and Prosthetics? ☐ Yes ☐ No
Are you an Orthotics and Prosthetics Facility that does fittings and alterations? ☐ Yes ☐ No
Are you a Distributor of Orthotics and Prosthetics (NO manufacturing, fitting or altering)? ☐ Yes ☐ No

9. If applicable, please provide a complete list of products that you manufacture (attach separate sheet if necessary)

_____

10. If applicable, please provide a complete list of products that you fit or alter (attach separate sheet if necessary)

_____

11. If applicable, please provide a complete list of products that you sell only - no manufacturing, fitting, alterations (attach separate sheet if necessary) _____

12. Do you manufacture, sell, fit or alter any implant devices? □ Yes □ No

If yes, complete provide list of devices _____

13. Does Applicant render professional service directly to patients without doctor's referral? □ Yes □ No

If yes, what? _____

14. Does Applicant perform or assist in any surgical procedures? □ Yes □ No

If yes, list all procedures and give us an exact description of your involvement _____

_____

15. What is your procedure for follow-up and ongoing communication with patients after the initial fitting and acclimation of the prosthesis (attach separate sheet if necessary)?_____

_____

16. Are you or is someone on your staff ABC certified? □ Yes □ No

17. Are you or is someone on your staff BOC Certified? □ Yes □ No

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

19. Do you provide continuing education for your employees? □ Yes □ No

20. Has any claim or suit been brought against your business or employees? □ Yes □ No

If yes, please provide details of claim including date of loss and dollar amount of loss (attach separate sheet if necessary) _____

_____

21. Are you aware of any circumstances, which may result in claim or suit being made or brought against your business or any of your employees? □ Yes □ No

If yes, provide details (attach separate sheet if necessary)_____

_____

PLEASE NOTE THAT CURRENTLY VALUED LOSS RUNS FOR THE LAST 5 YEARS ARE REQUIRED TO BIND COVERAGE

22. Please list all carrier information for the last 4 years.

Carrier Name _____ Policy Term: _____ Premium: _____

Carrier Name _____ Policy Term: _____ Premium: _____

Carrier Name _____ Policy Term: _____ Premium: _____

Carrier Name _____ Policy Term: _____ Premium: _____

23. Please list number of each type of professionals and the combined years experience for each type

TYPE OF PROFESSIONAL	NUMBER OF EMPLOYED PROFESSIONALS	YEARS EXPERIENCE IN THE ORTHOTICS/PROSTHETICS FIELD
Prosthetist		
Orthotist		
Orthotic/Prosthetic Fitter		
Lab Techs		
Nurse		
Other – Please Provide Details		

24. 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

YOUR APPLICATION CANNOT BE PROCESSED UNLESS COMPLETED IN ITS ENTIRETY.

Applicant's Warranty Statement: The undersigned represents to the best of his/her knowledge and belief the particulars and statements set forth are true and agree that those particulars and statements are material to the acceptance of the risk assumed by the Company. The undersigned further declares that any claim, incident or event taking place prior to the effective date of the insurance applied for which may render inaccurate, untrue, or incomplete any statement made will immediately be reported in writing to the applied for which may render inaccurate, untrue, or incomplete any statement made will immediately be reported in writing to the Company and the Company may withdraw or modify and outstanding quotations and/or authorization or agreement to bind the insurance. The signing of the Application does not bind the undersigned to purchase the insurance, nor does the review of the Application bind the Company to issue a policy. It is understood the Company is relying on the Application in the event th Policy is issued. It is agreed that this Application, including any material submitted therewith, shall be the basis of the contract should a policy be issued, and may be attached to and become part of the policy.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act.

_____ _____ _____

Signature of Applicant **Date** **Name and Title**

(Must be signed by principal, partner or officer of group or individual applying for insurance.)