3320 W. Cheryl Drive, Suite B-122
Phoenix, AZ 85051
PHONE: 913-275-5050
FAX: 855-535-3887
TOLL FREE: 888-329-0003

HOME MEDICAL EQUIPMENT DEALERS APPLICATION

PLEASE CONTACT YOUR AGENT WITH ANY QUESTIONS AND TO RETURN COMPLETED APPLICATION

1. Named Insured (full name of all companies to be insured under this policy):

_____

DBA: _____

Mailing Address: _____

Physical Loc #1: _____ SQ Feet _____

Physical Loc #2: _____ SQ Feet _____

Physical Loc #3: _____ SQ Feet _____

Attach a separate page if more than 3 locations

Contact Person**:** _____

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?_____

(NEW Ventures, please provide copy of resume/experience in the medical industry.)

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 transferable.**

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. Effective date requested _____

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 ☐ $2,000,000/$4,000,000
☐ $3,000,000/$3,000,000

8. Estimated Gross Revenue for the **next 12 months**:

Sales Revenue: $_____ Rental Revenue: $_____

Repair/Service Revenue: $_____ TOTAL: $_____

Actual Gross Revenue for the **past 12 months**: $_____

Send submissions to: alliedhealthbiz@vgmsu.com

9. Please provide a % breakout of who you are selling/renting equipment to. **TOTAL %'s MUST EQUAL 100%.**

Patient for home use: _____% Nursing homes:____% Assisted living facilities: _____%

Doctors offices: _____% Hospitals: _____% Other: _____% (explain) **Total: _____%**

10. Inventory (products handled) is based on your Gross Revenue in percentages. Gross Revenue percentages must equal 100%

Oxygen Concentrators	___%	Sell Grab Bars	___%	Apnea Monitors	___%
Oxygen Cylinders	___%	Install Grab Bars	___%		
				Beds, Crutches,	
Liquid Oxygen	___%			Walkers, Commodes	___%
Oxygen Valves/Reg	___%	Stair Lifts		Braces	___%
	___%	☐☐Commercial *	___%	CPAP/BiPAP	___%
Manual Wheelchairs	___%	☐☐Residential	___%	CPM	___%
Motor Wheelchairs	___%			Disposable	___%
Scooter/Tri-Carts	___%	Wheelchair Lifts		Enteral Therapy	___%
		☐☐In the Home	___%	Low Air Loss Mattress	___%
Auto Conversions *	___%	☐☐In Autos *	___%	Nebulizers	___%
Diabetic Shoes	___%			Parenteral Therapy	___%
Pharmacy *	___%			Tens Units	___%
Sleep Study Testing *	___%			Ventilators	___%

Please list any other items sold or rented below, along with a corresponding percentage for each item:

_____	___%	_____	___%	_____	___%
_____	___%	_____	___%	_____	___%

Total of All Three Columns (TOTAL MUST = 100%) **___%**

*** If commercial stair lifts, automobile conversions, wheelchair lifts "in autos," pharmacy or sleep Studies, please complete appropriate supplemental application.**

11. If selling diabetic shoes, please answer the following questions:

a. Are the shoes sold with a doctor's prescription? ❒ Yes ❒ No

b. Is there an orthotist or pedorthist on staff? ❒ Yes ❒ No

If yes, does the orthotist or pedorthist carry his/her own professional liability coverage? ❒ Yes ❒ No

If yes, what limits of liability does their policy carry? _____

c. What percentage, if any, are off-the-shelf items, such as braces, inserts, arches, etc? _____

d. Do you measure the patient's foot to determine shoe size needed or is that done by the doctor?

❒Measured by you ❒ Measured by doctor

e. If measured by you, what is the process for measuring? (Measuring stick, foot mold, etc.)?

_____

12. Do you obtain a Additional Insured – Vendor Endorsement from your manufacturers naming you as the additional insured? ☐ Yes ☐ No

13. Are you accredited by JCAHO? ☐ Yes ☐ No

14. Do you have a formal risk management procedure in place? ☐ Yes ☐ No

15. Do you provide continuing education to your employees? ☐ Yes ☐ No

Send submissions to: alliedhealthbiz@vgmsu.com

16. Do you service or repair any HME products other than those that you have sold/rented? ☐ Yes ☐ No
If yes, what items? _____
What % of your gross revenue is service work on equipment other than what you have sold/rented? _____
Do you provide any type of warranty on your service/repair work? ☐ Yes ☐ No
If yes, explain: _____

17. How many independent contractors (1099's) do you use for your HME business? _____
If yes, what are you using them for? _____
Do you want them added to your policy as Additional Insured? ☐ Yes ☐ No
If yes, please provide the name and address of each individual (ATTACH SEPARATE SHEET).

18. Do you contract or subcontract labor for installation, service or repair of any products? ☐ Yes ☐ No
If yes, what products? _____
Do you provide any type of warranty for contracted or subcontracted labor? ☐ Yes ☐ No
If yes, please explain _____

19. Do you install any equipment (involving the use of tools of any kind) in customer homes? ☐ Yes ☐ No
If yes, what equipment are you installing? _____
Do you provide any type of warranty for installations? ☐ Yes ☐ No
If yes, please explain _____

20. Do you perform sleep studies? (If yes, please complete supplemental application.) ☐ Yes ☐ No

21. Do you want a quote for Non-Owned Auto Liability? (If yes, complete supplemental.) ☐ Yes ☐ No

22. Do you want a quote for Hired Auto Liability? (If yes, complete supplemental.) ☐ Yes ☐ No

23. Have you had any known Products/Professional or General Liability losses in the last 5 years? ☐ Yes ☐ No
If yes, please provide details of claim(s) including date of loss and dollar amount of loss (attach separate sheet if necessary)! _____

_____

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

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: _____

24. Do you employ any certified professionals? ☐ Yes ☐ No
If yes, do they or you carry professional liability coverage? ☐ Yes ☐ No
Please state number of certified professionals by category:
Respiratory therapists _____ Nurses _____ Other, please describe _____

Describe their duties: _____

25. 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

Send submissions to: alliedhealthbiz@vgmsu.com

Policies are minimum earned premium and subject to audit for purposes of determining additional premiums only.

The warranties following will be made a part of any policy issued under this program.

WARRANTED: The company named on the front hereof and as signed below does not engage in any of the following activities:

A. Manufacture of any product.
B. Re-manufacture or re-building of any item (repairs allowed — see below)
C. Provide home health nursing, therapy or other medical or quasi-medical in nature services of any kind.
D. Charge a fee for medical related services.
E. Directly import any product.

WARRANTED: The company named on the front hereof and as named below will adhere to the following quality criteria to be eligible for (and remain eligible for) coverage under this insurance program:

A. Repair work allowed on equipment owned, rented or sold, by trained personnel and following manufacturer recommendations. No significant outside repair work is allowed.
B. If oxygen is offered, a true 24-hour service program must exist.
C. Insured must have and designate a "safety manager" to receive, catalog and disseminate all safety and loss control information.
D. No injections or IV administration may be done by an insured unless the individual so doing is properly licensed and the administration is incidental to the sale or rental of the equipment and not on a fee basis.
E. Van conversion must be disclosed and specifically approved by Insurer.

WARNING! This is an important document, which could affect your legal rights. Please **read it again carefully** and **be certain it is correct and complete**. Your signature below is your warranty to us that we can rely on this form. We have made no investigation of our own and the coverage decision will be based on this information. COVERAGE IS NOT BOUND OR STARTED BY THIS FORM. WE MAKE NO PROMISE TO INSURE. THIS IS ONLY A REQUEST FOR A QUOTE. YOU ARE NOT COVERED UNTIL AND UNLESS YOU RECEIVE A BINDER SO STATING.

The coverage that we are quoting from information on this form are Product/Completed Operations & Professional and/or General Liability Insurance. We base important decisions on your answers to these questions. If your answers are not correct or complete we could make a mistake and include people in the program who do not qualify or decline to offer coverage to those who do. We rely on the accuracy of your answers. If you have any questions about the form or your answers, please ask before completing the form.
The questions in this application are not intended to, nor do they, indicate the existence, non-existence or limitations on any items of coverage. This document does not in any fashion determine the coverage provided.

YOUR APPLICATION CANNOT BE PROCESSED UNLESS COMPLETED IN ITS ENTIRETY.

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

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

Send submissions to: alliedhealthbiz@vgmsu.com