Application

For

Medical Equipment (DME)
Sales/Rental/Lease

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1. Name of Applicant ______
   Street Address ______
   City ______ State ______ Zip ______
   Website Address ______

2. ☐ Individual ☐ Corporation ☐ Partnership ☐ Other (Explain) ______

3. List full names of individuals or partners and their interests: ______

4. Location of premises/operations (If same as above, write "Same") ______
   Street Address ______
   City ______ State ______ Zip ______

5. Date Established: ______

6. Provide the following information. If no prior insurance, check here. ☐

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

7. Proposed Effective Date: ______ Proposed Exp. Date: ______

   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 $ ______
   Fire Damage Limit (up to $50,000 limit available) $ ______ any one (1) fire
   Medical Expense Limit (up to $5,000 limit available) $ ______ any one (1) person
   Each Professional Incident Limit (if applicable) $ ______

8. Premises Exposure
   Building ______ ACV/RC ______ Co. Ins. ______
   Contents ______ ACV/RC ______ Co. Ins. ______
   Bus Income ______ EE ______
   Construction of Building? ______ Number of Floors? ______
   Age of Building? ______ Sprinklered? ______
   Central Alarm? ______

   Protection Class 1-8 ______
   Protection Class 9 & 10 ______
   Area (square footage)? ______

9. **Product Information**

CHECK-OFF ITEMS BEING SOLD, RENTED OR LEASED:

		Do you carry? Yes	No	Rent or Sales		Do you install? Yes	No
1.	Apnea Monitors	______	______	______	______	______	______
2.	Arterial Pressure Monitors	______	______	______	______	______	______
3.	Anesthesia Equipment	______	______	______	______	______	______
4.	Blood Gas Analyzing Equipment	______	______	______	______	______	______
5.	Bi-Paps	______	______	______	______	______	______
6.	C-Paps	______	______	______	______	______	______
7.	Cardiac Output Machine	______	______	______	______	______	______
8.	Defibrillators	______	______	______	______	______	______
9.	Grab Bars	______	______	______	______	______	______
10.	IPPB	______	______	______	______	______	______
11.	Infusion Therapy Equipment	______	______	______	______	______	______

Please circle equipment – (Enteral-Parenteral Chemotherapy-Antibiotic Therapy-Chemotherapy-Antibiotic foods-disposable tubing)

		Do you carry? Yes	No	Rent or Sales		Do you install? Yes	No
12.	Intensive Care Incubators	______	______	______	______	______	______
13.	Laser Equipment	______	______	______	______	______	______
14.	Life Function Monitoring	______	______	______	______	______	______
15.	Medical Gas Piping System	______	______	______	______	______	______
16.	Oxygen Equipment	______	______	______	______	______	______

Sub-Contract ☐ Yes ☐ No / Do you follow standard suppliers procedures ☐ Yes ☐ No

		Do you carry? Yes	No	Rent or Sales		Do you install? Yes	No
17.	Pace Makers	______	______	______	______	______	______
18.	Resuscitators	______	______	______	______	______	______
19.	Small Volume Nebulizuers	______	______	______	______	______	______
20.	Stair Lifts	______	______	______	______	______	______
21.	Trascutaneous Nerve Stimulators	______	______	______	______	______	______
22.	Ventilators – Life Support	______	______	______	______	______	______
23.	Vertical (hoyer) Lifts	______	______	______	______	______	______
24.	Wheel Chairs – Standard	______	______	______	______	______	______
25.	Wheel Chairs - Power	______	______	______	______	______	______
26.	Wheel Chair – Lifts	______	______	______	______	______	______
27.	Motorized/Electrical Scooters	______	______	______	______	______	______
28.	X-Ray Equipment	______	______	______	______	______	______
29.	Other-Specify-Attach Listing						

CHEMOTHERAPY

30.	Prepare Drugs	___	___	Position	______	Employed	______	Sub-Contractor	______
31.	Administer Drugs	___	___	Position	______	Employed	______	Sub-Contractor	______
32.	Training for use of Equipment	___	___	Position	______	Employed	______	Sub-Contractor	______

Closed Pharmacy (Only) –Not open to general public please list all compounds prepared:

A) ____________________ B) ____________________ C) ____________________

* Attach Brochure

Professional Liability Information

10. If you use certified professionals, please state number of professionals by category

	Employed	Contracted
Respiratory Therapist		
Nurses		
Orthotics		
Prosthetics		
Other		
Description		

Do you always verify licensing/certification? ☐ Yes ☐ No
Do they carry their own GL Liability Insurance? ☐ Yes ☐ No
Do they carry their own Prof. Liability Insurance? ☐ Yes ☐ No
Do you require annual Certificates of Insurance? ☐ Yes ☐ No
What limits do they carry? $ ____________

11. 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. $ ____________

12. Do manufacturers name you as Vendor/Additional Insured? ☐ Yes ☐ No
If yes, please attach Certificate of Insurance.

13. What foreign-made products are sold? Please list. ____________

14. Any sales of used equipment? Gross sales. ☐ Yes ☐ No $ ____________
Specify types. ____________

15. Describe any sales outside the U.S. Gross sales. $ ____________

16.

Additional Insureds	Interests	Do you require certificates?

FRAUD NOTICE: Any person who knowingly and with intent to defraud any insurance company files an application for insurance or statement of claim containing any materially false information or conceals for the purposes of misleading, information concerning any fact or material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Applicant's Signature: ____________ Date: ____________

Title: ____________ Producing Agent ____________