

Cailor Fleming Insurance
P.O. Box 3989
Youngstown, Ohio 44513
Phone: 800-796-8495
Fax: 330-782-0874

DME/HME Program Application

Policy Effective Date: _____

Account Information

Insured's Name: _____
Mailing Address: _____
City: _____ State: _____ Zip: _____ Phone: _____
Contact Name: _____ Fax: _____
Coastal State: Yes / No If yes, distance to body of water: _____ Number of Locations: _____
Do you have a WEBSITE? Yes / No If yes: _____
EMAIL ADDRESS: _____

Description of Operations

Corporation: Yes / No Type: _____ Individual: Yes / No
Provide a brief description of operations, including years in business: _____

If new venture, provide years experience: _____
Any business conducted other than DME or O&P: Yes / No If yes, please describe: _____

Current Carrier: _____ Premium: _____ Yrs with Carrier: _____
Prior Insurance Carrier and Policy Date: _____

Practitioner for Patient Care Certified: Yes / No

Professional Liability Occurrence Claims Made Prior Acts Date _____
(Attach Copy of Prior Claims Made Policy Declarations if requesting Prior Acts.)

General Liability Occurrence Claims Made Prior Acts Date _____
(Attach Copy of Prior Claims Made Policy Declarations if requesting Prior Acts.)

Please Indicate if you: Sell / Rent / Distribute / Repair Any of the Following Equipment
For Each Type, Please Check Box and Indicate Sales Amount

<input type="checkbox"/> Monitoring Equipment	\$	<input type="checkbox"/> TENS Units	\$
<input type="checkbox"/> Diagnostic Equipment	\$	<input type="checkbox"/> Halos / Cranial Helmets	\$
<input type="checkbox"/> Life Sustaining Equip.	\$	<input type="checkbox"/> Devices that are implanted	\$
<input type="checkbox"/> Oxygen Support	\$	<input type="checkbox"/> Wheelchairs/Cots/Gurneys	\$
<input type="checkbox"/> Respiratory Support	\$	<input type="checkbox"/> Grab Bars	\$
<input type="checkbox"/> Respirators	\$	Do you Install?	YES / NO
<input type="checkbox"/> Vehicle Control Devices	\$	Yrs. Experience Installing?	_____
<input type="checkbox"/> Hoists	\$	<input type="checkbox"/> Pharmaceuticals, Drugs	\$
<input type="checkbox"/> Lifts	\$	<i>(Please List on Separate Page)</i>	
<input type="checkbox"/> Ramps	\$	<input type="checkbox"/> Buy / Sell / Repair	\$
<input type="checkbox"/> Hand Controls	\$	Used Equipment	
<input type="checkbox"/> Other Auto Related Equip.	\$	<input type="checkbox"/> Installation of Stair Chairs	\$
<input type="checkbox"/> Surgical Equipment	\$	<input type="checkbox"/> Installation of Patient Lifts	\$

If provider does installation of equipment, how many years of installation experience? _____

Please Indicate Estimated Sales for Each Category :

	<u>Last Year</u>	<u>Next Year</u>
Practitioner Patient Care: Includes all items you make, fit, alter, adjust for patients. No patient care for this class.	\$ _____	\$ _____
Manufacturing: Items manufactured by and sold to others to distribute.	\$ _____	\$ _____
Wholesale Distribution: Includes all items purchased from others that you resell to other facilities.	\$ _____	\$ _____
Retail Customers (DME): Include items that you rent/sell to others over the counter that you do not repackage, change, or modify.	\$ _____	\$ _____
Medical Equipment: Repair or Installation of any type of lift.	\$ _____	\$ _____

Please provide a specific description for any "Checked" responses from the previous page. If available, please provide brochures with submission. _____

Do you re-package or re-label any items? YES / NO If yes, please explain: _____

General Information

Member of any of the following? : (Please circle) AOPA AAOP Pedorthic Footwear Assoc.
Other : _____

Is the Facility Accredited? : YES / NO
If yes, By Who and What Year? : _____

Please Provide the Following Regarding Staff :

# of Full Time Employees: _____		Part Time: _____	Independent Cont: _____	
Position	# Employed	Yrs. Employed	Ind. Cont.	Other
Practitioner				
Respiratory Therapist				
Nurse				
Technician				
Physical Therapist				

Facility Safety

Central Station Alarm System for : Fire, Smoke, Break-in YES / NO Monitored 24 hours a day? YES / NO

Are all stairs covered with anti-slip treads? : YES / NO

Are handrails provided on all stairways? : YES / NO Hallways? : YES / NO

Are parking lots free of debris and are surfaces smooth? : YES / NO

Exterior of building well lit? : YES / NO

Are the edges of curbs, sidewalks and steps color coded to identify raised surfaces? : YES / NO

Who is responsible for the maintenance of building, such as snow/ice removal? : _____

Please explain any "NO" responses : _____

Do you lease any part of the premises to another business or are there any other business activities, other than HME/DME, conducted on the premises that are not directly related to the coverage being requested on this application? If so, please explain _____

Property Description / Locations :

<u>FULL Location Address</u>	<u># of Stories</u>	<u>Construction / PC</u>	<u>Year Built</u>	<u>Sprinkler System</u>	<u>Sq. Feet</u>
1)					
2)					
3)					
4)					
5)					

Note: If requesting building coverage and the building is over 30 years old, please provide information when the roof, plumbing, electrical & heating systems have been updated: _____

If a coastal state, please indicate locations' roof type: _____

<u>Coverage :</u>	<u>Location #1</u>	<u>Location #2</u>	<u>Location #3</u>	<u>Location #4</u>	<u>Location #5</u>
Building Value :					
Contents Value :					
Out Buildings (Garage, Sheds, etc.) :					
**Note: Values should be 100% Replacement Cost. Unless otherwise requested or noted, all deductibles are \$500.					

General Questions

Have you or anyone ever been convicted of fraud, arson or any other crimes related to a property loss in the last five years? YES / NO

How close is the nearest fire department? _____ Miles

Are there any fire hydrants with-in 200 feet of the building? YES / NO

Who has access to cash registers/safes? _____

Who has check writing authority? _____

Are pre-employment criminal background checks done? YES / NO Run MVR's? YES / NO

Do you make daily deposits? YES / NO Do you use an armed guard service? YES / NO

How many individuals work with accounts payable? _____

Do you require those working with accounts to take at least a weeks' vacation? YES / NO

<u>General Liability</u>	<u>Limits</u>	<u>General Liability</u>	<u>Limits</u>
General Aggregate	3 Mil	Professional Liability	3 Mil
Each Occurrence	1 Mil	Employee Benefit Liability	
Damage to Premises You Rent	300,000	Hired & Non-Owned Auto Liab.	
Medical Payments	5,000	Stop Gap Liability	

Have you had any losses or filed any claims in the past 3 years? YES / NO

If yes, please describe below:

<u>Description of Loss</u>	<u>Date of Loss</u>	<u>Amount Paid</u>

Do you require all vendors, manufacturers, distributors and any independent contractor to:

Provide a Certificate of Insurance to show that the above carries and maintains coverage? YES / NO

(Please provide copies of these certificates, if applicable.)

Additional Insured – Please list Names and Addresses Below and their Interest in your Operations.

<u>Name & Address</u>	<u>Interest of Additional Insured</u>
1) _____	_____
2) _____	_____
3) _____	_____

Would you like a quote for :

Flood Insurance	YES / NO	Wind Insurance	YES / NO
Directors/Officers	YES / NO	Employment Practice Liab. Coverage	YES / NO

Would you like an Umbrella? YES / NO If yes, Limit desired \$ _____

(Supplemental Application Required.)

If yes for Umbrella, do you need any of the following: Primary Auto Liab. Premium : _____
Work Comp Liab. Limit : _____

<u>Number of Auto(s)</u>	<u>Private Pass.</u>	<u>Trucks</u>	<u>Vans</u>

Fraud Statement

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

Date : _____ Applicants Signature : _____