Cailor Fleming Insurance
P.O. Box 3989
Youngstown, Ohio 44513
***Phone*: 800-796-8495**
***Fax*: 330-782-0458**

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** Federal Tax ID#: __________________
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.)

General Information

Member of any of the following? : *(Please circle)* AOPA AAHomecare Pedorthic Footwear Assoc.
Other : _________________________________

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

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
Have you had any insurance losses or filed any claims in the past 3 years? YES / NO
If yes, please describe below:

Description of Loss	Date of Loss	Amount Paid

Please Indicate if you: Sell / Rent / Distribute / Repair Any of the Following Equipment

For Each Type, Please Check Box and Indicate % of Sales

❑ Monitoring Equipment	%	❑ TENS Units	%
Type of Equipment: (Please List)		❑ CPAP / BYPAP	%
1)		❑ Halos / Cranial Helmets	%
2)		❑ Buy / Sell / Repair Used Equipment (Please List)	%
❑ Diagnostic Equipment (Please List)	%		
1)		1)	
2)		2)	
❑ Life Sustaining Equip. (Please List)	%	❑ Devices that are implanted	%
1)		❑ Vehicle Control Devices	%
2)		❑ Hoists	%
❑ Oxygen Support (Please List)	%	❑ Wheelchairs/Cots/Gurneys	%
1)		❑ Lifts	%
2)		❑ Ramps	%
❑ Diabetic Shoes	%	❑ Installation of Stair Chairs	%
❑ Respiratory Support	%	❑ Grab Bars	%
❑ Respirators	%	Do you Install?	**YES / NO**
❑ Hand Controls	%	Years Experience Installing?	___________
❑ Other Auto Related Equip.	%	❑ Pharmaceuticals, Drugs	%
❑ Surgical Equipment	%	(*Please List on Separate Page*)	
❑ Disposables	%	❑ Installation of Patient Lifts	%

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

Please Indicate Estimated Annual Sales for Each Category :	Last Year Sales	Next Year Sales
Practitioner Patient Care: Includes all items you make, fit, alter, adjust for patients.	$_______________	$_____________
Manufacturing: Sales of manufactured items by and sold to others to distribute. No patient care for this class.	$_______________	$_____________
Wholesale Distribution: Sales of all items purchased from others that you resell to other facilities.	$_______________	$_____________
Retail Customers (DME): Sales of items that you rent/sell to patients or customers over the counter that you do not repackage, change, or modify.	$_______________	$_____________
Medical Equipment: Sales of Repair or Installation of any type of Medical Equipment.	$_______________	$_____________

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

Do you directly import any foreign products into the U.S.? YES / NO If yes, please list products ___________
____

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.)

Please Provide the Following Regarding Staff and Patient Services :

# of Full Time Employees: ______	Part Time: ______	Independent Cont: _____

Position	# Employed	Yrs. Employed	Ind. Cont.	Other
Practitioner				
Respiratory Therapist				
Nurse				
Technician				
Physical Therapist				
Pharmacist				

____

____

1. Total number of employees providing services for patients: ____________
2. Total number of patient contracts currently in place, if any: ______________
3. Describe the services provided by your employees while on the premises of your patients:
   ____
   ____
4. Are any services performed for contracted clients/patients off the clients' premises? If yes, please describe:____
   ____
5. Do you verify the employment background of prospective employees? _____________________________
6. Do you use non-employees to perform patient services? If yes, how many? __________________________
   ____
7. Describe supervisory procedures for all individuals engaged in performing patient services:
   ____
   ____

Pharmacy Exposure

Is there a pharmacy at any of the Business locations listed on this application? YES / NO

1. How many pharmacists are on staff? __________

a. *Are they employees or independent contractors?* ____

2. What are the names of the pharmacist(s)?

a. ____________________________________ c. ____________________________________

b. ____________________________________ d. ____________________________________

3. Does the pharmacist carry their own Pharmacist Professional Liability Policy? YES / NO

If yes, with whom and what are the policy limits? ____

4. Please confirm that only the licensed pharmacist re-labels, repackages, and/or compounds the pharmaceuticals. YES / NO

Property Description / Locations :

FULL Location Address	# of Stories	Construction / PC	Year Built	Sprinkler System	Sq. Feet
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: ____

Property Description (Please fill out if requesting Property Quote)

Coverage :	Location #1	Location #2	Location #3	Location #4	Location #5
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.					

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 ____

____

____

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

Name & Address | Interest of Additional Insured

1)____

2)____

3)____

4)____

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 a quote for an Umbrella Policy, to go over the existing policy limits?

YES / NO

(*Please Note: Most information for the Auto & Workers Comp Policies can be found on the Declaration Pages of those policies.*)

If yes, what limit is desired $_______________ (Limits start at $1 million and up.)

If yes for Umbrella, please include the following: (*Note: Underwriter Can Not Quote without this information*)

Commercial Auto Insurance:

Effective Dates: ______________________
Name of Auto Insurance Carrier: ______________________________ Policy Number: ____________________
Auto Liability Insurance Limit: $_____________________________ Premium for Auto Liab. Only: $___________
How Many Autos? _________________

Private Passenger	Light Trucks *(Pick-Ups, etc...)*	Heavy Trucks *(Box Trucks, etc..)*	Vans

Do any of the vehicles travel more than 51 miles for a delivery? YES / NO If yes, which ones? ___________
Any Commercial Auto Losses in the last 5 Years? YES / NO If yes, please list and describe loss: _______
____
____
____

Workers Compensation Insurance:

Effective Dates: ______________________
Name of WC Insurance Carrier: ______________________________ Policy Number: _____________________
Workers Comp Insurance Limits: $_________________________ Premium for Workers Comp.: $___________
Any Losses over $100,000 in the past 4 years? YES / NO If yes, please list and describe loss: ___________
____
____
____

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 : ____

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