

**Cailor Fleming Insurance**

**P.O. Box 3989**

**Youngstown, Ohio 44513**

**1-800-796-8495**

**Orthotics and Prosthetics Program**

**Application**



**AMERICAN  
ORTHOTIC & PROSTHETIC  
ASSOCIATION**

SERVING THE O&P FIELD FOR OVER 90 YEARS

AOPA Member Yes  No

Policy Effective Date: \_\_\_\_\_

<b>Account Information</b>		email address: _____	
Insureds Name: _____			
Mailing Address: _____			Fax: _____
City: _____	State: _____	Zip: _____	Phone: _____
Contact Name and Phone number: _____			
Coastal State: Yes No	If yes, distance to body of water: _____	Number of locations: _____	
Do you have a WEB site Yes No if yes: _____			
<b>Description of Operations:</b>		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 Orthotics & Prosthetics: Yes No. If yes, please describe: _____			
Current Insurance Carrier: _____		Premium: _____	Years with carrier: _____
Prior Insurance Carriers and policy dates: _____			
Practitioner for Patient Care Certified by ABC or BOC: Yes No			

Please indicate estimated sales for each category:	Last Year	Next Year
<b>Practitioner Patient Care:</b> Includes all items fabricated for patients. <b>Custom products.</b>	\$	\$
<b>Manufacturing:</b> Items manufactured by and sold to others to distribute. There is no patient care for this class.	\$	\$
<b>Wholesale Distribution:</b> Includes all items purchased from others that you resell to other facilities.	\$	\$
<b>Retail Customers:</b> Includes pre-fab items that you rent/sell to others over the counter that you do not repack or change. Includes 'prefab' custom fit braces.	\$	\$
<b>Medical Equipment Repair:</b>	\$	\$

Please indicate if you: sell, rent, distribute, repair, any of the following types of equipment:			
	Yes	No	% Sales
Monitoring or, diagnostic equipment, life sustaining equip.			
Oxygen, respiratory support or respirators			
Vehicle control devices			
Hoists, lifts, ramps hand controls or auto related equipment			
Surgical Equipment			
TENS units			
Halos or Cranial Helmets			
Devices that are implanted			
Wheelchairs, cots, gurneys			
Grab Bars			
Pharmaceuticals, drugs			
Buy, sell or repair used equipment			

**Cailor Fleming is the NEW Exclusively Endorsed AOPA Provider.**

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Supplemental Application

Please provide a specific description for any "Yes" response in the above. If available, please provide brochures with submission. \_\_\_\_\_  
 Do you repackage or re-label any items? **Yes No** If yes, please explain: \_\_\_\_\_

<b>General Information:</b>	
Member of any of the following:	Is the facility ABC Accredited: <b>Yes No</b> If <b>Yes</b> what Year ____
AAOP <b>Yes No</b>	Pedorthic Footwear Association <b>Yes No</b>
	Other: _____

**Please provide the following regarding staff:**

Position	# Employed	Yrs. Employed	Ind. Cont.	Other
<b>Total Number of Employees</b>				
Practitioner				
Fitter				
Technician				
Physical Therapist				

**Facility Safety**

Central station alarm 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** Is exterior of building well lit? **Yes No**  
 Are the edges of curbs, sidewalks and steps color coded to identify raised surface? **Yes No**  
 Who is responsible for the maintenance of building, such as snow/ice removal:  
 Please explain any "NO" response: \_\_\_\_\_  
 Do you require all vendors, manufactures, distributors and any independent contractor to provide a Certificate of Insurance? **Yes No**  
 Do you require them to carry limits equal or greater than your limits? **Yes No**

**Additional Insureds** - Please list name and address below and their interest in your operations.

Name/Address of Additional Insured	Interest of the Additional Insured
1	
2	

**Property Description/Locations**

FULL Location Address	# of stories	Construction/PC	Year Built	Sprinklered	Square feet
1					
2					
3					
4					

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

**General Questions:**Have you or anyone ever been convicted of fraud, arson or other crimes related to a property loss in the last 5 yrs? **Yes No**

How close is the nearest fire department? \_\_\_\_\_ miles

Are there any fire hydrants with-in 200 feet of building? **Yes No**

Who has access to cash registers, safes? \_\_\_\_\_

Who has check writing authority? \_\_\_\_\_

Are pre-employment criminal background checks done? \_\_\_\_\_ 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**

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, all deductibles are \$500.					

Would you like a quote for:	Flood Ins?	Wind Ins?	Directors/Officers
	Y/N	Y/N	Y/N

**Would you like a quote for Employment Practice Liability coverage? Yes No****Have you had any losses in the past 3 years? Yes No If yes please describe:**

Description of loss	Date of loss	Amount Paid			

General Liability:	Limit			
General Aggregate:	\$3,000,000		Professional Liability	\$3,000,000
Each Occurrence:	\$1,000,000		Employee Benefit Liability	\$ _____
Damage to premises you rent	\$300,000		Hired & Non-Owned Auto Liab.	\$1,000,000
Medical Payments	\$5,000		Stop Gap Liability:	\$ _____

**Would you like an Umbrella? Yes No If yes Limit desired \$ \_\_\_\_\_ . Supplemental Application will be required.**If **Yes** for Umbrella need the following: Primary Auto Premium: \_\_\_\_\_ Work Comp Liability Limit: \$ \_\_\_\_\_

Number of auto(s):	Pri. Pass	Trucks	Vans

**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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