Cailor Fleming Insurance
P.O. Box 3989
Youngstown, Ohio 44513
1-800-796-8495

Medical Equipment Repair Program Application

Policy Effective Date: _____

Account Information

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: _____

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 Medical Equipment Repair: **Yes No**. If yes, please describe:

_____

Current Insurance Carrier: _____ Premium:_____ Years with carrier:____

Prior Insurance Carriers and policy dates: _____

Technician Certified : **Yes No**

Please indicate estimated sales for each category:

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

Please indicate if you: sell, rent, distribute, repair, any of the following types of equipment:

	Yes	No	% Sales	Installation recipts
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 **(Do you install Yes No**)				$
Pharmaceuticals, drugs				$
Buy, sell or repair ***used*** equipment				$
Installtion of Stair Chairs				$
Installtion of Patient Lifts				$

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Medical Equipment Repair Program
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: _____

General Information:

Member of any of the following:	Is the facility certified? **Yes No**		If **Yes** what Year ___		
Professional Association? **Yes No**					
	Other: _____				

Please provide the following regarding staff:

Position	# Employed	Yrs. Employed	Ind. Cont.	Other
Total # of Employees				
Respiratory Therapist				
Nurse				
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

***DO YOU DO ANY DIRECT IMPORTATION OF FOREIGN PRODUCTS? YES NO**

If yes, please explain _____

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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