



Orthotics and Prosthetics Program Application

Effective Date: _____

Please note that within the application we have identified certain exposures with a red flag. If these exposures are present in your business, we'll need for you to provide more detailed information in the "Red Flag" portion of the application.

I. ACCOUNT INFORMATION

1. Name of each entity that is requesting coverage, including DBAs: _____

2. Mailing Address: _____ City: _____ State: _____ Zip: _____

3. Physical Address:

1. _____	City: _____	State: _____	Zip: _____
2. _____	City: _____	State: _____	Zip: _____
3. _____	City: _____	State: _____	Zip: _____
4. _____	City: _____	State: _____	Zip: _____
5. _____	City: _____	State: _____	Zip: _____
6. _____	City: _____	State: _____	Zip: _____

4. Contact Name and Phone Number: _____

5. Coastal State: Yes ☐ No ☐ (If yes, distance to body of water) _____

6. Do you have a website? Yes ☐ No ☐ (If yes, URL) _____

7. Email address: _____

8. Date business was established: _____

II. DESCRIPTION OF OPERATIONS

1. ☐ Individual ☐ Partnership ☐ Corporation

2. Federal Tax ID# _____

3. Provide a brief description of operations for each entity requesting coverage: _____

4. Any business conducted other than Orthotics & Prosthetics? Yes ☐ No ☐ (If yes, please describe) _____


5. If new venture, please explain your prior experience, how many years and position this experience is in: _____

6. Practitioner for Patient Care Certified by ABC or BOC? Yes ☐ No ☐

7. Check off if you are a member of any of the following:

☐ AAOP ☐ Pedorthic Footwear Association ☐ AOPA ☐ Other: _____

8. Is the facility accredited? Yes ☐ No ☐ If yes, by whom: _____

9. Do all entities requesting coverage have common ownership? Yes ☐ No ☐  (If the Named Insured is only one entity, Please leave blank)

10. Are you a subsidiary of another entity? Yes ☐ No ☐ 

11. Do you have any subsidiaries? Yes ☐ No ☐ 

12. Have you acquired any new entities within the past 12 months? Yes ☐ No ☐ 

13. Are you planning on adding any new entities? Yes ☐ No ☐ 

14. Current Insurance Carrier: _____ Premium: _____ Years with carrier: _____

III. CLAIMS HISTORY

1. Have you had any losses in the past 3 years? Yes ☐ No ☐ (If yes, please describe below)

Description of loss	Date of loss	Amount paid








IV. PLEASE INDICATE ESTIMATED SALES FOR EACH CATEGORY

(If the majority of your sales include manufacturing, sales, repair/service and/or installation of Durable Medical Equipment (DME), please complete the Durable Medical Equipment application.)

	Est. sales for current term
Practitioner Patient Care: Includes all items that you make, fit, alter or adjust for patients. Including custom products.	\$
Manufacturing: Items manufactured by you and sold to others to distribute. There is no patient care for this class. Is this a Central Fabrication Facility: Yes <input type="checkbox"/> No <input type="checkbox"/> or a Mass Manufacturer: Yes <input type="checkbox"/> No <input type="checkbox"/>	\$
Wholesale Distribution: Includes all items purchased from others that you resell to other facilities. No direct sales to patients.	\$
Retail Sales: Includes all items you rent/sell to customers with no alteration or relabeling/repackaging. Includes but not limited to crutch tips, stump socks, shoes, braces, etc. Including prefabricated custom braces.	\$
Other: Please provide details on the operations being performed that don't meet the other categories listed above:	\$

V. Indicate if You: Manufacture, Sell, Rent, Repair or Install any of the following products by checking Yes or No

If you check yes, please indicate the percentage of annual sales for that product. 

	Yes	No	% Sales
Halos or Cranial Devices 			
Products that are implanted or used in surgery 			
Scooters/Power Wheelchairs 			
TENS units			
Wheelchairs (other than power wheelchairs) 			
Buy, sell or repair used equipment 			
Do you perform invasive procedures? Please explain: _____			
Do you sell, distribute or repair any invasive products? (example: Knee replacement parts, etc.) 			
Are there any other products that apply that are not listed above? 			

1. For any operation that does repair / service / install of products, please confirm the following:

1a. Are detailed records of all repairs / services / installation kept on file? Yes ☐ No ☐

1b. Are the manufacturer's instructions followed on all repairs/services/installations? Yes ☐ No ☐

If no, please explain: _____

2. Do you repackaging or relabel any items? Yes ☐ No ☐ 

3. Do you do any direct importation of foreign products? Yes ☐ No ☐ 

4. Do you require all vendors, manufacturers, distributors and contractors you do business with to provide proof of insurance? Yes ☐ No ☐

4a. IF YES, do you require them to carry limits equal to or greater than your limits? Yes ☐ No ☐

4a. IF NO, will you implement the practice of requesting proof of insurance? Yes ☐ No ☐

5. Is there any subcontracted work? Yes ☐ No ☐ If yes:

5a. What work is the subcontractor doing? _____

5b. Are current certificates of insurance collected from the subcontractors? Yes ☐ No ☐

5c. Are you named as an AI on the subcontractor's policy? Yes ☐ No ☐

5d. Do you require the subcontractor to carry limits equal to or greater than your limits? Yes ☐ No ☐

6. Do you or any employee perform or assist in any surgical procedures? Yes ☐ No ☐

If yes, please explain: _____

7. If you own the building, are there any other occupancies? ☒ Yes ☐ No ☐

VI. GENERAL QUESTIONS

1. Have you or anyone ever been convicted of fraud, arson or other crimes related to a property loss in the last 5 years? ☒ Yes ☐ No ☐

2. Have there been any bankruptcies in the past 3 years? Yes ☐ No ☐

If yes, what type and what is the status? _____

VII. PLEASE PROVIDE THE FOLLOWING REGARDING OWNERS AND STAFF

Total number of employees (Including Owners): _____

Please break out the number of Owners, Employees and Independent Contractors by position below.

Position	Owners	#Employed	Independent Contractor
Practitioner			
Fitter			
Technician			
Physical Therapist			
Other: _____ (Please provide description of any owners/staff &/or Independent Contractors that doesn't fit the position listed above.)			

VIII. GENERAL LIABILITY LIMITS

General Liability	Limit	Medical Expense:	\$ 5,000
General Aggregate:	\$3,000,000	Professional Liability:	Included
Products/Completed Operations Aggregate:	\$3,000,000	Employee Benefit Liability:	\$ _____
Each Occurrence:	\$1,000,000	Hired and Non-Owned Auto Liability:	\$1,000,000
Damage to Premises Rented to You	\$ 300,000	Stop Gap Liability: (For OH, ND, WY, WA)	\$ _____

If you are requesting limits other than what is listed above, please specify the limits you are requesting: _____

IX. ADDITIONAL INSURED

Please list name and address below and their interest in your operations

Name / Address of Additional Insured	Interest of Additional Insured
1. Name: Address:	
2. Name: Address:	

X. PROPERTY INSURANCE

Yes ☐ No ☐

Please complete the following information for each location for which you are requesting Property Insurance

Premises information:	Location #1	Location #2	Location #3	Location #4	Location #5	Location #6
Occupancy: Office, warehouse, other (Please specify other)						
Do you occupy entire space? Please answer Yes or No						
Building Limit *						
Business Personal Property Limit *						
Business Income/Extra Expense Limit *						
Out Buildings (Garage, Sheds, etc.) *						
Number of Stories						
Construction **						
Protection Class						
Year Built						
Square Feet (only applies if building coverage is being requested)						
Roof type (please choose from: Wood-Shake or Shingles, Built Up, Tile or Clay, Steel or Metal) ***						
Year of last update on the roof ***						
Year of last update on electrical system ***						
Year of last update on plumbing system ***						
Year of last update on heating system ***						
Do you/business own the building? Please answer Yes or No						
Is the building on a historical registry or in a historical district? Please answer Yes or No						
Does the building have aluminum wiring? Please answer Yes or No						
If the building has aluminum wiring, is it pigtailed? Please answer Yes or No						
Is there Knob and Tube wiring? Please answer Yes or No						
Is there any outdoor property, I.E. a fence, that needs to be added to the property schedule? If yes, please list the type of property and limit being requested for that property.						
\$25,000 Off-Premises Power Outage Coverage (interruption of utility services). Please specify whether or not you would like this coverage included by answering "Yes" or "No".						

* Values should be at least 90% replacement cost.

** Construction type: A=Wood B=Joisted Masonry C=Masonry Non-Combustible or Fire Resistive Construction

*** Only required if the building is older than 30 years and/or if requesting any property coverage and location is in a coastal state.


XI. EXCESS LIABILITY

This policy is designed to provide additional limits in excess of your General Liability and/or Auto Liability and Employers Liability (if applicable)

(Please note: Most information for the Auto and Workers Compensation Policies can be found on the declaration pages of those policies.)

1. Would you like a quote for an Excess Policy to go over the existing policy limits? Yes ☐ No ☐
2. If yes, what limit is desired? _____ (Limits start at \$1 million and up)
3. If yes for Excess, please include the following: (Note: Underwriter cannot quote without this information)

Commercial Auto Insurance:

1. Name of Auto Insurance Carrier: _____
2. Effective and expiration dates: _____
3. Policy Number: _____
4. Auto Liability Insurance Limit: \$ _____
5. Premium for Auto Liability Only (Include Hired Auto and Non-Owned Auto Liability Premiums if applicable): _____
6. Does the policy provide Hired Auto? Yes ☐ No ☐ and/or Non-Owned Auto? Yes ☐ No ☐
7. Vehicle list: Number of: _____ PPT's, _____ Light, _____ Medium, _____ Heavy
8. Garaging: Are all vehicles garaged at the same location?
 - 8a. Yes - What is the garaging location? (City, State, Zip): _____
 - 8b. No - What is the garaging location for each vehicle? (City, State, Zip): _____
9. Vehicle use: _____ Service, _____ Commercial, _____ Retail.
10. Radius of operation: Is the majority of driving less than 100 miles? Yes ☐ No ☐
 - 10a. If more than 100 miles, how often and under what circumstances? _____
11. Are there any drivers that are not at least 20 years of age and/or any drivers that do not have a minimum of 2 years driving experience? Yes ☐ No ☐ 
 - 11a. if a driver is over the age of 75, a completed physician's statement is needed.
12. Have you had any at fault auto liability losses greater than \$100,000? Yes ☐ No ☐
 - 12a. If yes, please provide date of loss, description of loss: _____
 - 12b. Is loss open or closed? Open ☐ Closed ☐
 - 12c. What is the amount reserved or paid? _____
13. For risks with more than 25 power units:
 - 13a. Are Motor Vehicle Reports (MVRs) ordered? Yes ☐ No ☐
 - 13b. Are Motor Vehicle Reports (MVRs) reviewed at least once per year on all drivers? Yes ☐ No ☐
 - 13c. Is a loss control program in place? Yes ☐ No ☐
14. Are there any "public vehicles" defined as contract business, taxi cabs or livery for hire - fee paid for using or transporting passengers? Yes ☐ No ☐

Employers Liability Insurance:


1. Workers Compensation Insurance Carrier: _____
2. Effective date: _____
3. Policy Number: _____
4. Employers Liability Limits: _____
5. Any losses in the past 5 years? Yes ☐ No ☐
 - If yes, please list and describe loss including reserve amounts or paid amounts

Is it open or closed: _____
Is it a Workers Compensation loss or an Employers Liability loss: _____

XII. WOULD YOU LIKE A QUOTE FOR:

- | | |
|--|---|
| Flood Insurance | Yes <input type="checkbox"/> No <input type="checkbox"/> (Please complete separate Flood Application) |
| Wind Insurance | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Directors and Officers | Yes <input type="checkbox"/> No <input type="checkbox"/> (Please complete separate D & O Application) |
| Employment Practices Liability Coverage | Yes <input type="checkbox"/> No <input type="checkbox"/> (Please complete separate EPLI Application) |

RED FLAG SECTION

Throughout the application there are several questions marked with a "Red Flag" . If these questions are answered "yes", or information has been provided where asked, we will need details as to the questions below. You may answer the question(s) below directly or provide explanatory narrative on a separate page.

Section II question #9

Do all entities requesting coverage have common ownership? (common ownership refers to collective ownership of property by two or more persons)

Please provide the following information:

***Name Insureds:** (If more than one Named Insured is to be on the policy, please answer the following for all entities)

Entity 1-	Entity Name including dba: _____ Nature of operation: _____ Ownership Percentage(s): _____
Entity 2-	Entity Name including dba: _____ Nature of operation: _____ Ownership Percentage(s): _____
Entity 3-	Entity Name including dba: _____ Nature of operation: _____ Ownership Percentage(s): _____

Please provide similar information if more than three entities to be scheduled on policy.

Section II question #10 & 11

Are you a subsidiary of another entity or do you have any subsidiaries?

Describe relationship to the parent company and if there is a relationship to any medical facility:

Section II question #12 & 13

Have you acquired any new entities within the past 12 months or planning on adding any new entities?

1. Provide details on any new or projected entities and anticipated sales or answer "n/a" if this doesn't apply.
2. Please provide details on any new or projected locations and anticipated sales or answer "n/a" if this doesn't apply.
3. Please provide details on any major pending contracts and anticipated sales or answer "n/a" if this doesn't apply.

Section V

After each product, please indicate if you manufacture, sell, rent, repair or install any of the products by checking the box. Also, please answer any additional questions under each product that applies:

Halos or Cranial Devices:

Who performs attachment of these devices: ☐ Patient Physician ☐ O & P Practitioner

Does the O & P Practitioner set the pins into the skull? Yes ☐ No ☐

Does the O & P Practitioner tighten the pins that are already set into the skull? Yes ☐ No ☐

Products that are implanted or used in surgery, please provide a list of products and what is being done with those products:

Invasive Products

Please provide a list of products: _____

What are these products used for? _____

Please include brochures, pictures, complete descriptions of each product with your submission.

Scooters, power wheelchairs:

☐ Manufacture ☐ Sell ☐ Rent ☐ Repair/Service ☐ Install

Please provide a description of the types of service work performed on the scooters and/or power wheelchairs:

Wheelchairs:

☐ Manufacture ☐ Sell ☐ Rent ☐ Repair/Service ☐ Install

What type of repairs are being done? _____

RED FLAG SECTION (continued)

Buy, sell, or repair used equipment:

Please indicate the types of equipment and whether you are buying, selling or repairing that equipment:

Is this equipment serviced by a qualified individual or company? Yes ☐ No ☐

What types of repairs are being done on this equipment, if applicable? If not applicable, please mark "n/a".

Are there any other products that apply that are not listed above?

☐ Manufacture ☐ Sell ☐ Rent ☐ Repair/Service ☐ Install

Please provide a list of product(s) and description of product(s)

What are these products used for and/or what is being done with these products?

Section V Question 2

Do you repackage or relabel any items? Please provide the following additional information:

1. What product(s) is/are being repackaged and/or relabeled?

2. What percent of your annual gross sales do these products make up?

3. Are you modifying these products or changing these products in any way? Yes ☐ No ☐

If yes, please provide a complete explanation including what changes or modifications you are making to the product:

4. Do you replace the manufacturer's label with your label on any wholesale or retail product you distribute? Yes ☐ No ☐

Section V Question 3

Do you do any direct importation of foreign products:

1. Do you use an import broker Yes ☐ No ☐ If yes, what is the name and address of the import broker?

2. Please provide a list of products that are imported:

3. What percentage of total annual sales are products imported from foreign countries?

4. What country are these products imported from?

5. Are the imported products a key component of the overall product? Yes ☐ No ☐

Section V Question 7

If you own the building, are there any other occupancies?

1. Please specify which location, the type of occupancy and include the square footage for each:

Section VI Question 1

Have you or anyone ever been convicted of fraud, arson, or other crimes related to a property:

1. Please provide whether it was fraud, arson or other property crimes:

2. Who was charged and for what and when:

Section XI Commercial Auto Section Question 11

Are there any drivers that are not at least 20 years of age and/or any drivers that do not have a minimum of 2 years driving experience?

Please provide the name and date of birth for each driver that is not at least 20 years old with at least 2 years of prior driving experience

Name	Date of birth
Name	Date of birth
Name	Date of birth
Name	Date of birth
Name	Date of birth

FRAUD STATEMENTS

Applicable in AL, AR, DC, LA, MD, NM, RI and WV

Any person who knowingly (or willfully)* presents a false or fraudulent claim for payment of a loss or benefit or knowingly (or willfully)* presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. *Applies in MD only.

Applicable in CO

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Applicable in FL and OK

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony (of the third degree)*. *Applies in FL only.

Applicable in KS

Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

Applicable in KY, NY, OH and PA

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties* (not to exceed five thousand dollars and the stated value of the claim for each such violation)*.

*Applies in NY only.

Applicable in ME, TN, VA and WA

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties (may)* include imprisonment, fines and denial of insurance benefits. *Applies in ME only.

Applicable in NJ

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Applicable in OR

Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.

Applicable in PR

Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars (\$5,000) and not more than ten thousand dollars (\$10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Applicant's Signature

Date

Title (Must be President, Chairman, CEO, Director, Sole Proprietor, Partner or CFO)

Producer's Name

Date

Producer's Signature