CAILOR FLEMING INSURANCE
"Insuring your World"
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Youngstown, Ohio 44513
1-800-796-8495
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DME/HME PROGRAM APPLICATION

Requested Policy Effective Date: _____

I. ACCOUNT INFORMATION

1. Business Name: _____
2. Mailing Address: _____
3. City: _____ State: _____ Zip: _____ Phone: _____
4. Contact Name and Phone Number: _____ Fax: _____
5. Coastal State: Yes ☐ No ☐ If yes, distance to body of water: _____ 6. Number of locations: _____
7. Do you have a website? Yes ☐ No ☐ *If yes, URL:* _____
8. **E-mail address:** _____

II. DESCRIPTION OF OPERATIONS

1. Corporation: Yes ☐ No ☐ Type: _____ Individual: Yes ☐ No ☐ **FEDERAL TAX ID #:** _____
2. Provide a brief description of operations including years in business: _____

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

4. **Practitioner for Patient Care Certified? Yes ☐ No ☐**
5. Any business conducted other than DME or O&P? Yes ☐ No ☐ *5a. If yes, please describe:* _____

6. Current Insurance Carrier: _____ Premium: _____ Years with carrier: _____
7. Prior Insurance Carrier and Policy Date: _____

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.)

8. Member of any of the following: AAOP ☐ AAHomecare ☐ Pedorthic Footwear Assoc. ☐ AOPA ☐
Other: _____
9. Is the facility Accredited? Yes ☐ No ☐
9a. If yes, by who and what year?: _____

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. 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 ☐

2a. If yes, what type and what is the status? _____

V. PLEASE INDICATE IF YOU: SELL, RENT, DISTRIBUTE, REPAIR, ANY OF THE FOLLOWING TYPES OF EQUIPMENT:

For each type, please check box and indicate % of sales (must equal 100%)

☐ Monitoring equipment	%	☐ TENS Units	%
Type of equipment (Please List)		☐ CPAP/ BYPAP	%
1.		☐ Halos ☐ Cranial Helmets	%
2.		Used Equipment (Check all that apply) ☐ Buy ☐ Sell ☐ Repair	%
☐ Diagnostic equipment	%	Type of equipment (Please List)	
Type of equipment (Please List)		***1.***	
1.		***2.***	
2.		If selling used equipment has it been serviced by qualified individual or company?	Yes ☐ No ☐
☐ Life Sustaining equipment	%	☐ Products that are implanted or used in surgery	%
Type of equipment (Please List)		☐ Vehicle Control Devices	%
1.		Is the Auto Conversion Endorsement needed?	Yes ☐ No ☐
2.		☐ Hoists	%
☐ Oxygen Support	%	☐ Wheelchairs/ Cots/ Gurneys (other than power wheelchairs)	%
Type of equipment (Please List)		☐ Lifts	%
1.		☐ Ramps	%
2.		☐ Installation of Stair Chairs	%
☐ Diabetic Shoes	%	☐ Grab Bars	%
☐ Respiratory Support	%	Do you install?	Yes ☐ No ☐
☐ Respirators	%	Years experience installing?	_____
☐ Hand Controls	%	☐ Pharmaceuticals, Drugs	%
Is the Auto Conversion Endorsement needed?	Yes ☐ No ☐	(please list on a separate page)	
☐ Other Auto Related Equipment	%	☐ Installation of Patient Lifts	%
Is the Auto Conversion Endorsement needed?	Yes ☐ No ☐	☐ Perform invasive procedures	%
☐ Surgical Equipment- please provide list	%	☐ X-Ray calibration	%
☐ Disposables	%	☐ Scooters ☐ Repair ☐ Rental	
☐ Power Wheelchairs	%	Do you sell, distribute or repair any invasive products (example: Knee replacement parts, etc.)	Yes ☐ No ☐

1. If provider does installation or repair of equipment, how many years of installation & or repair experience?: _____

VI. PLEASE INDICATE THE BREAKOUT OF PROJECTED ANNUAL RECEIPTS PER CATEGORY FOR THE UPCOMING POLICY PERIOD:

	Estimated updated sales for current term
Practitioner Patient Care: Includes all items you make, fit, alter, adjust for patients. No patient care for this class.	$
Manufacturing: Sales of manufactured items by you 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. No direct patient sales	$
Retail Customers (DME): Sales/ Revenue of items that you rent/ sell to patients or customers over the counter that you do not repackage, change or modify.	$
Medical Equipment: Sales/ Revenue of Repair or Installation of any type of Medical Equipment. (No retail sales of equipment)	$

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? If no, please provide explanation. Yes ☐ No ☐

2. Do you re-package or re-label any items? Yes ☐ No ☐
2a. If yes, please explain:
2b. Are manufacturer labels kept on product or removed?

3. Do you do any direct importation of foreign products? Yes ☐ No ☐
If yes, please answer the following:
3a. Do you use an import broker? If yes, please provide name and address of import broker. Yes ☐ No ☐
3b. Please provide a list of products that are imported:
3c. What percentage of total annual sales are products imported from foreign countries?
3d. What country are these products imported from?
3e. Are the imported products a key component of the overall product? Yes ☐ No ☐

3. Do you require all vendors, manufacturers, distributors and contractors you do business with to provide proof of insurance? Yes ☐ No ☐
*3a. **If no**, will you implement the practice of requesting proof of insurance?* Yes ☐ No ☐
*3b. **If yes**, do you require them to carry limits equal to or greater than your limits* Yes ☐ No ☐

4. Any subcontracted work? Yes ☐ No ☐
5. What is the cost of subcontractors?
6. What work is the subcontractor doing?

VII. PLEASE PROVIDE THE FOLLOWING REGARDING STAFF:

# of full time employees: _____ **# of part time employees:** _____ **# of independent contractors:** _____

Position	# Employed	Independent Contractor
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? Yes ☐ No ☐
4a. If yes, please describe:

5. Do you verify the employment background of prospective employees? Yes ☐ No ☐
6. Do you use non-employees to perform patient services? Yes ☐ No ☐
6a. If yes, how many?:

7. Describe supervisory procedures for all individuals engaged in performing patient services:

VIII. PHARMACY EXPOSURE

1. Is there a pharmacy at any of the Business locations listed on this application? Yes ☐ No ☐

2. How many pharmacists are on staff?: _____

3. Are they employees or independent contractors?: _____

4. What are the names of the pharmacist(s)?:

a. _____ c. _____

b. _____ d. _____

5. Does the pharmacist carry their own Pharmacist Professional Liability Policy? Yes ☐ No ☐

5a. If yes, with whom and what are the policy limits?: _____

6. Please confirm that only the licensed pharmacist re-labels, repackages, and/ or compounds the pharmaceuticals. Yes ☐ No ☐

IX. PROPERTY DESCRIPTION/ LOCATIONS

FULL Location Address	# of stories	Construction	Protection Class	Year Built	Sprinklered	Square feet
1.						
2.						
3.						
4.						
5.						

1. **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: _____

2. **If a coastal state, please indicate locations' roof type and roof update information:** _____

3. Do you/ business own the building? Yes ☐ No ☐ 3a. ***If yes, is there any outdoor property, I.E. a fence, that needs to be added to the property schedule?*** Please list: _____

4. Are the buildings on a historical registry or in a historical district? Yes ☐ No ☐

5. 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, and specify which locations:

6. Is there aluminum wiring? Yes ☐ No ☐ *6a. If yes, is it pigtailed?* Yes ☐ No ☐

7. Is there knob and tube wiring? Yes ☐ No ☐

X. PROPERTY DESCRIPTION (Please fill out if requesting Property Quote)

Property Coverage:	Location #1	Location #2	Location #3	Location #4	Location #5
Building Value					
Contents Value					
Business Income/Extra Expense Value					
Out Buildings (Garage, Sheds, etc)					

Note: Values should be 100% Replacement Cost.

XI. FACILITY SAFETY

1. Central station alarm for (check all that apply): Fire ☐ Smoke ☐ Break In ☐ Monitored 24 hours a day?(check all that apply): Fire ☐ Smoke ☐ Break In ☐

2. Please specify locations: _____

3. Who is responsible for the maintenance of the building, sidewalks and parking areas? _____

XII. GENERAL LIABILITY

General Liability	Limit	General Liability	Limit
General Aggregate:	$3,000,000	Professional Liability:	$3,000,000
Each Occurence:	$1,000,000	Employee Benefit Liability:	$ 1000000
Damage to premises you rent:	$300,000	Hired & Non-Owned Auto Liability:	$1,000,000
Medical Payments:	$5,000	Stop Gap Liability (for OH, ND, WA & WY):	$

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

XIII. ADDITIONAL INSUREDS- Please list name and address below and their interest in your operations

Name/Address of Additional Insured	Interest of Additional Insured and Form #
1.	
2.	

XIV. WOULD YOU LIKE A QUOTE FOR:

1. Flood Insurance — Yes ☐ No ☐ (Please complete separate Flood Application)
2. Wind Insurance — Yes ☐ No ☐
3. Directors & Officers — Yes ☐ No ☐
4. Employment Practice Liability coverage — Yes ☐ No ☐ (Please complete separate EPLI Application)

XV. Would you like a quote for an Excess 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 Declarations Pages of those policies)

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

2. 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 Date:_____
3. Policy Number:_____
4. Auto Liability Insurance Limit: $_____
5. Premium for Auto Liability Only: $_____

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. Vehicle use:_____ Service, _____ Commercial, _____ Retail

9. Radius of Operation: Is the majority of driving less than 100 miles? Yes ☐ No ☐

*9a. If more than 100 miles, how often and under what circumstances?*_____

10. Are all drivers at least 23 years of age with a minumum of 5 years driving experience? Yes ☐ No ☐

10a. If a driver is over the age of 75, a completed physician's statement is needed.

11. Have you had any at fault auto liability losses greater than $100,000? Yes ☐ No ☐

*11a. If yes, please provide date of loss, description of loss:*_____

*11b. Is loss open or closed?*_____

*11c. What is that amount reserved or paid?*_____

12. 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. Name of WC Insurance Carrier: _____ 2. Effective Date: _____

3. Policy Number: _____

4. Employers Liability Insurance Limits: $ _____ 5. Premium for Workers Comp: $ _____

6. Any losses in the past 5 years? Yes ☐ No ☐

6a. If yes, please list and describe loss including reserve amounts or paid amounts and whether the loss is open or closed:

_____

_____

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 facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder 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 that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or 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 (Use the pencil tool found under the tools menu to sign digitally) Date

_____

Title

Save and e-mail completed Medical Equipment Repair/Service/Installation to: dfoley@cailorfleming.com
Save and e-mail completed DME/HME to: wmcmahon@cailorfleming.com