Member Companies of Western World Insurance Group

☐ Western World Insurance Company
☐ Tudor Insurance Company

Application For

Medical Equipment (DME) Sales/Rental/Lease Liability

1. Name of Applicant _____
   Street Address _____
   City _____ State _____ Zip _____
   Applicant's Web Site Address _____
2. Date Established _____ *and* Type of Organization ☐ Individual ☐ Partnership ☐ Corporation
   ☐ Other (Please explain.) _____
3. Please provide full names of individuals or partners and their interests: *(If needed, continue on Attachment to A17.)*
   Name _____ Interest _____
   Name _____ Interest _____
   Location of premises/operations. ☐ Check if SAME as above.
   Street Address _____
   City _____ State _____ Zip _____
4. Please provide the following information. ☐ Check if no prior insurance.

Insurance Company	Policy Period	Limits of Liability	Premium	Type of Coverage Occurrence or Claims Made

5. During the past **three (3) years**, have any claims been presented to your current or prior insurance carrier(s)? *(If yes, please provide description of claim(s), date of loss, amount(s) paid and reserved on Attachment to A17.)* ☐ Yes ☐ No
6. Is the applicant, or any other person for whom insurance is being requested, aware of any circumstances which may result in a claim? (*If yes, please provide full details on Attachment to A17.)* ☐ Yes ☐ No
7. **Professional Liability Information** – If applicant uses certified professionals, please state number by category.

	Employed	**Contracted**
Therapists	_____	_____
Nurses	_____	_____
Orthotist	_____	_____
Prosthetist	_____	_____
Other	_____	_____

   Description _____
   _____
   Does applicant always verify licensing/certification? ☐ Yes ☐ No
   Do certified professionals carry own General Liability insurance? ☐ Yes ☐ No
   Do certified professionals carry own Professional Liability insurance? ☐ Yes ☐ No
   Does applicant require annual Certificates of Insurance? ☐ Yes ☐ No
   What limits do certified professionals carry? $_____
8. Show separate gross sales for items sold. $ _____
   Show separate gross sales for items rented/leased. $ _____
   Total estimated gross sales for the upcoming year. $ _____
   Show payroll for service or repair by employees. $ _____
   Show cost for installation and repair work subcontracted. $ _____
   Show sales of re-conditioned or used equipment $ _____
   Show sales of reprocessed medical equipment or devices $ _____

9. **Product Information** – Check-off items being sold, rented or leased.

	Do you carry?	Rent or Sales	Do you install?
Apnea Monitors	☐ Yes ☐ No	☐ Rent ☐ Sales	☐ Yes ☐ No
Arterial Pressure Monitors	☐ Yes ☐ No	☐ Rent ☐ Sales	☐ Yes ☐ No
Anesthesia Equipment	☐ Yes ☐ No	☐ Rent ☐ Sales	☐ Yes ☐ No
Blood Gas Analyzing Equipment	☐ Yes ☐ No	☐ Rent ☐ Sales	☐ Yes ☐ No
Bi-Paps/V-Paps	☐ Yes ☐ No	☐ Rent ☐ Sales	☐ Yes ☐ No
C-Paps	☐ Yes ☐ No	☐ Rent ☐ Sales	☐ Yes ☐ No
Cardiac Output Machine	☐ Yes ☐ No	☐ Rent ☐ Sales	☐ Yes ☐ No
Diabetic Equipment *(Please attach list.)*	☐ Yes ☐ No	☐ Rent ☐ Sales	☐ Yes ☐ No
Defibrillators	☐ Yes ☐ No	☐ Rent ☐ Sales	☐ Yes ☐ No
Dialysis Equipment	☐ Yes ☐ No	☐ Rent ☐ Sales	☐ Yes ☐ No
Durable Medical Equipment	☐ Yes ☐ No	☐ Rent ☐ Sales	☐ Yes ☐ No
Expendable Medical Supplies	☐ Yes ☐ No	☐ Sales	N/A
Grab Bars	☐ Yes ☐ No	☐ Rent ☐ Sales	☐ Yes ☐ No
IPPB *(Intermittent Positive Pressure Breathing)*	☐ Yes ☐ No	☐ Rent ☐ Sales	☐ Yes ☐ No
Infusion Therapy Equipment	☐ Yes ☐ No	☐ Rent ☐ Sales	☐ Yes ☐ No

If yes, please list: _____

Infusion Therapy Services Provided ☐ Yes ☐ No

If yes, please list: _____

If yes, where done? ☐ Patient's Home ☐ Hospital ☐ Nursing Home/Assisted Living

Intensive Care Incubators	☐ Yes ☐ No	☐ Rent ☐ Sales	☐ Yes ☐ No
Laser Equipment	☐ Yes ☐ No	☐ Rent ☐ Sales	☐ Yes ☐ No
Life Function Monitoring	☐ Yes ☐ No	☐ Rent ☐ Sales	☐ Yes ☐ No
Medical Gas Piping System	☐ Yes ☐ No	☐ Rent ☐ Sales	☐ Yes ☐ No
Operating Room Equipment	☐ Yes ☐ No	☐ Rent ☐ Sales	☐ Yes ☐ No
Oxygen Equipment	☐ Yes ☐ No	☐ Rent ☐ Sales	☐ Yes ☐ No
Sub-contracted? ☐ *Yes* ☐ *No*	*Does applicant follow standard suppliers procedures?* ☐ *Yes* ☐ *No*		
Pace Makers	☐ Yes ☐ No	☐ Rent ☐ Sales	☐ Yes ☐ No
Resuscitators	☐ Yes ☐ No	☐ Rent ☐ Sales	☐ Yes ☐ No
Small Volume Nebulizers	☐ Yes ☐ No	☐ Rent ☐ Sales	☐ Yes ☐ No
Stair Lifts	☐ Yes ☐ No	☐ Rent ☐ Sales	☐ Yes ☐ No
Transcutaneous Nerve Stimulators	☐ Yes ☐ No	☐ Rent ☐ Sales	☐ Yes ☐ No
Ventilators – Life Support	☐ Yes ☐ No	☐ Rent ☐ Sales	☐ Yes ☐ No
Vertical (Hoyer) Lifts	☐ Yes ☐ No	☐ Rent ☐ Sales	☐ Yes ☐ No
Wheel Chairs – Standard	☐ Yes ☐ No	☐ Rent ☐ Sales	☐ Yes ☐ No
Wheel Chairs – Power	☐ Yes ☐ No	☐ Rent ☐ Sales	☐ Yes ☐ No
Wheel Chairs – Lifts	☐ Yes ☐ No	☐ Rent ☐ Sales	☐ Yes ☐ No
Motorized/Electrical Scooters	☐ Yes ☐ No	☐ Rent ☐ Sales	☐ Yes ☐ No
X-Ray Equipment	☐ Yes ☐ No	☐ Rent ☐ Sales	☐ Yes ☐ No
Other *(Specify – please attach listing.)*	☐ Yes ☐ No	☐ Rent ☐ Sales	☐ Yes ☐ No

Chemotherapy	**Licensed/Certified**	**Employed**	**Sub-Contractor[(1)]**
Prepare Drugs ☐ Yes ☐ No	☐ Yes* ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
** If yes, please explain License/Certification* _____			
Administer Drugs ☐ Yes ☐ No	☐ Yes* ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
** If yes, please explain License/Certification* _____			
Training for Use of Equipment ☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

[(1)] *If sub-contracted, are Certificates of Insurance required?* ☐ Yes ☐ No

Closed Pharmacy (ONLY) – Not open to the general public; please list all compounds prepared.

(A) _____ (B) _____ (C) _____

10. Do manufacturers name you as Vendor/Additional Insured? ☐ Yes ☐ No
(If yes, please attach Certificate of Insurance.)

11. What foreign-made products are sold? *(Specify – attach listing.)*
12. Any sales of used equipment? ☐ Yes ☐ No Gross sales: $ _____
13. Describe any sales outside the U.S. on Attachment to A17. Gross sales: $ _____
14. Please provide the following information.

Additional Insureds	Interests	Certificate of Insurance Required?
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

15. LIMITS OF INSURANCE REQUESTED:

General Aggregate Limit (Other Than Products – Completed Operations)	$ _____	
Products – Completed Operations Aggregate Limit	$ _____	
Personal and Advertising Injury Limit	$ _____	
Each Occurrence Limit	$ _____	
Damage to Premises Rented by You (Up To $100,000 Limit Available)	$ _____	Any One (1) Premises
Medical Expense Limit (Up To $5,000 Limit Available)	$ _____	Any One (1) Person
Each Professional Incident Limit (If Applicable)	$ _____	

FOR SEXUAL MOLESTATION COVERAGE , PLEASE COMPLETE QUESTIONS 16 THROUGH 20.
$25,000/50,000 limit is included **if there is Professional Coverage** at no additional charge. Higher limits are available for an additional premium charge(see below). If sexual molestation coverage for Professionals is not desired, please check here ☐ Coverage is NOT requested.

16. Has your facility had any incidents or claims brought against it for sexual molestation or any other allegation of misconduct? ☐ Yes ☐ No
    Please provide details _____
17. Has any facility that you have been associated with in the past ever had any incidents occur or claims brought against it while you were there? ☐ Yes ☐ No
    Describe _____
18. Does your facility do background checks on all employees and volunteers? ☐ Yes ☐ No
    Describe type of checks performed (prior employer, police, etc.) _____
19. Are there written guidelines in place regarding sexual misconduct? ☐ Yes ☐ No
    If NO, please explain _____
20. Please check the limits you are requesting: ☐ $25,000/50,000 - included
    ☐ $50,000/100,000 ☐ $100,000/300,000 ☐ 300,000/600,000 ☐ $500,000/1MM ☐ $1MM/2MM
21. Premises Exposure:
    Building _____ ACV/RC _____ Co. Ins. _____
    Contents _____ ACV/RC _____ Co. Ins. _____
    Business Income _____ EE _____
    Construction of Building? _____ # of Floors? _____ Age of Building? _____
    Sprinklered? ☐ Yes ☐ No Alarmed? ☐ Yes ☐ No
    Protection Class 1-8 _____ Protection Class 9&10 _____ Area (Sq. Ft.) _____

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22. Effective Dates Desired – From: ______________________________ To: ______________________________

FRAUD NOTICE: Any person who knowingly and with intent to defraud any insurance company files an application for insurance or statement of claim containing any materially false information or conceals for the purposes of misleading, information concerning any fact or material thereto commits a fraudulent insurance act, which is a crime and subjets such person to criminal and civil penalties.

Applicant's Signature ______________________________ Date ______________________________

Title ______________________________ Producing Agent ______________________________

#	Description or Full Details