ALLIED HEALTHCARE MEDICAL PRODUCTS SALES OR EQUIPMENT RENTAL PROFESSIONAL LIABILITY APPLICATION

Instructions: Answer all questions; applicant's name must include the names of all businesses and locations for which coverage is desired; attach a separate sheet if necessary. If an answer is none, state none. If the answer is not applicable, state (N/A). If the space provided is insufficient to fully answer the question, please attach a separate sheet.

Please type or print in ink.

PART I. GENERAL INFORMATION

1. Applicant Name:_____

2. Mailing Address:_____

_____

3. Location Address(es):_____

_____

4. County (parish) of Each Location:_____

_____

5. Telephone Number: Office:_____ Fax:_____

6. Person to Contact for Survey: Name:_____ Title:_____

7. Date Established:_____

8. The applicant is:
   [ ] Sole Practitioner
   [ ] Sole Proprietorship
   [ ] Partnership
   [ ] Corporation
   [ ] Other; Describe:_____

9. Gross Annual Receipts: Estimated Next 12 Months: $_____
   Last 12 Months: $_____

10. Entity is: [ ] For Profit [ ] Non-Profit
    Describe source of funds:_____

11. List memberships in professional organizations: _____

PART II. EXPOSURES

1. List each product or equipment line individually and provide receipts for each. Attach a copy of your products/equipment brochures.

Describe Product/Equipment Line	Annual Receipts From Rental	Annual Receipts From Sales
A.		
B.		
C.		
D.		
E.		

2. Describe clients applicant sells/rents to, and percentage of each:

_____% Individuals using products in their home

_____% Individuals in nursing homes*

_____% Nursing homes or similar residential facilities*

_____% Hospitals*

_____% Clinics/labs*

_____% Physicians*

_____% Other*; Describe _____

*If other than individuals in their home, is there a financial/ownership relationship between applicant and client or facility? [ ] Yes [ ] No

If Yes, explain:_____

3. Who does the servicing and repair of the products?_____

4. Are any products manufactured by others and sold under your entity's label? [ ] Yes [ ] No

If yes, which products?_____

5. Are any additional products planned in the next twelve months? [ ] Yes [ ] No

If yes, include them under question A, and estimate the receipts in the next 12 months.

6. How are products marketed? (attach ad copy or brochures)_____

_____

7. Is a rental/lease agreement signed by customers prior to releasing any rental equipment? [ ] Yes [ ] No

If yes, please enclose a copy of the rental agreement.

8. Is formal written inspection program for rental equipment conducted prior to each rental? [ ] Yes [ ] No

9. Are manufacturer's labels/directions/instructions provided to customers for all rentals? [ ] Yes [ ] No

10. Do the manufacturers or distributors of any of the above listed items:

(a) Name your entity as an additional insured under their products liability policies? [ ] Yes [ ] No

(b) Provide Certificates of Insurance for Products Liability to you? [ ] Yes [ ] No

(c) Provide maintenance/service agreements for their product(s)? [ ] Yes [ ] No

(d) Hold you harmless for loss arising from their products? [ ] Yes [ ] No

Please provide an explanation for any yes answer:_____

_____

11. Are all manufacturers/suppliers well-known U.S. firms? [ ] Yes [ ] No

If no, give details of which are not and any foreign products:_____

_____

12. If sales of medicines or drugs are made by applicant, is a licensed pharmacist employed or contracted? [ ] Yes [ ] No

If, yes indicate number: _____Employed (W-2) _____Contracted (1099)

13. Does pharmacist carry his/her own professional liability insurance? [ ] Yes [ ] No

PART III. RISK MANAGEMENT

1. Total number of staff: _____

2. Total payroll last year: _____

Total payroll next year: _____

3. Do you desire coverage for independent contractor(s) as additional insured(s) on your policy while working on your behalf? [ ] Yes [ ] No

Do you require contracted staff to carry their own Professional Liability Insurance and secure Certificates of Insurance as evidence of such coverage? [ ] Yes [ ] No

If yes, indicate minimum limits required: _____

4. Do you conduct pre-employment screening and investigation? [ ] Yes [ ] No

5. Do you prepare job descriptions and instructional manuals for your staff? [ ] Yes [ ] No

6. Are you equipped with an emergency 24-hour telephone call line for all staff: [ ] Yes [ ] No

7. Do you enter into any contractual agreements (other than lease of premises agreements)? [ ] Yes [ ] No

If yes, attach explanation.

8. Has the applicant or have any of the above employees:

a. ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital or professional association? [ ] Yes [ ] No

b. ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? [ ] Yes [ ] No

c. ever been treated for alcoholism or drug addiction? [ ] Yes [ ] No

d. ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same? [ ] Yes [ ] No

If Yes to any of the above, please explain.

PART IV. HISTORY

1. List prior **professional liability** insurers for the past five years, starting with the most recent year. If none, state none.

Insurer	Policy number	Limit of liability	Premium	Effective Dates	Claims-made (Y/N)

What is the most recent retroactive date?_____

2. List prior **general liability** insurers for the past five years, starting with the most recent year. If none, state none.

Insurer	Policy number	Limit of liability	Premium	Effective Dates	Claims-made (Y/N)

What is the most recent retroactive date?_____

3. Have any claims been made or occurrences reported during the past six years against any of the proposed insureds or against any entity in which any proposed insured has or has had an interest? [ ] Yes [ ] No

If yes, please describe; indicate status of the claim or suit and any amount(s) paid or reserved

(attach an additional sheet if necessary):

4. Does any proposed insured have any knowledge of an event, circumstance, or occurrence (other than any listed in 4.3 above) prior to the effective date of the proposed policy, or does any proposed insured foresee that a claim may be brought as a result of said event, circumstance, or occurrence? [ ] Yes [ ] No

If yes, describe the event and indicate the reason for anticipation of a claim:

I understand and agree this Application and any and all supplements attached hereto may be made a part of any policy issued, and any such policy will be issued in reliance upon the representation made herein. I further understand and agree that failure to provide a true and accurate response to the foregoing questions may, at the option of the Company, result in the voiding of insurance issued in reliance on this Application and/or denial of claims under any policy issued.

I authorize and consent to investigations of information bearing upon moral character, professional reputation, and fitness to engage in the activities of my business including authorization to every person or entity, public or private, to release to the company providing insurance coverage and MarketScout, any documents, records, or other information bearing upon the foregoing.

I understand and agree these investigations shall not be confined to information submitted in this application, but shall include any other sources of information deemed relevant by the Company as may be authorized by law.

Applicant and all owners, employees, and contractors are licensed or duly authorized in all states or jurisdictions where professional services are provided. Applicant warrants the truth of all answers to the above questions, and applicant has not withheld information which is calculated to influence the judgment of the insurance company in considering this application.

Important: This application must be dated and signed by the applicant owner, partner, officer or administrator. Signing this form does NOT bind the company to complete the insurance.

Applicant Signature

Title

Date