Commonwealth Underwriters Ltd.
P.O. Box 5441 Richmond, VA 23220
Phone: 800-396-6226
Fax: 888-359-6994
www.commund.com

MEDICAL EQUIPMENT SUPPLY STORES APPLICATION

Applicant's Name _____

Mailing Address _____

_____

Location _____

_____

(Please complete a separate application for each location.)

Agent Name _____

Address _____

_____

_____

PROPOSED EFFECTIVE DATE:
From _____ To_____

12:01 A.M., Standard Time at the mailing address of the Applicant.

Applicant is: ❑ Individual ❑ Corporation ❑ Partnership ❑ Joint Venture
❑ Limited Liability Company ❑ Other (Specify): _____

LIMITS OF LIABILITY REQUESTED **PREMIUMS**

General Aggregate		$	Premises/Operations $
Products & Completed Operations Aggregate		$	
Personal & Advertising Injury		$	Products/Completed Operations $
Each Occurrence		$	
Fire Damage (any one fire)		$	Other $
Medical Expense (any one person)		$ Excluded	
Professional Limit	Each Medical Incident	$	Professional $
	Aggregate	$	
Other Coverages, Restrictions, and/or Endorsements			Total $
	Deductible	$	

1. **Full Named Insured** (if not shown above): _____
_____

2. **Type of operation and annual sales:**
   - ❑ Sale of Medical, Hospital and Surgical supplies $ _____
   - ❑ Rental/leasing of home care products/equipment to consumers $ _____
   - ❑ Pharmacy $ _____
   - ❑ Other – Describe: _____
_____

3. Are Patrons fitted with rehabilitative items prescribed by doctors, such as back braces or neck collars? ❑ Yes ❑ No
   If Yes, Is the person doing the fitting an accredited surgical appliance technician? ❑ Yes ❑ No.

4. Percentage of equipment sold or leased/rented which is physician prescribed: _____%

5. Percentage of operations from sale of non-medical products, such as office furniture, printed materials (labels, charts, prescription forms), scales, etc.? _____%

6. Sale or rental of oxygen and respiratory equipment, such as oxygen concentrators, cylinders and aspirators?
   ❑ Yes ❑ No. If Yes, percentage of total operation: _____%
7. Do you deal in the sale or rental of any other gases? ❑ Yes ❑ No. If Yes, describe:_____
   _____
   Do you do any refilling of oxygen (or other gases)? ❑ Yes ❑ No

8. Do you buy or sell used equipment? ❑ Yes ❑ No. Percentage of total operation _____%
   If Yes, do you recondition/repair, prior to resale? ❑ Yes ❑ No
   Do you sell "as is"? ❑ Yes ❑ No

9. Do you subcontract repair or installation operations? ❑ Yes ❑ No. If Yes, do you obtain Hold Harmless Agreements from your subcontractors? ❑ Yes ❑ No.

10. Is equipment maintenance performed and documented according to manufacturers guidelines? ❑ Yes ❑ No.

11. Are customers given any applicable Material Data Safety Sheets prepared by the equipment manufacturer?
    ❑ Yes ❑ No

12. What are your procedures for reporting any malfunctioning devices to the Federal Drug Administration?
    _____
    _____

13. Sale, rental or leasing of any of the following equipment or machines? Indicate by "x".

___Anesthesia apparatus	___Inhalation therapy machines	___Cardiac Defibrillators
___X-ray, fluoroscopy	___Resuscitation equipment	___Radiation therapy
___Kidney machines	___Audiometers	___EKG machines
___Diathermy machines	___Suction or Irrigation apparatus	___Ventilators
___Oscilloscopes	___Metal & foreign body locators	___Heart Monitoring

14. Do you manufacture or directly import any medical/ surgical equipment? ❑ Yes ❑ No
    If Yes, provide details: _____
    _____

15. Do you employ or subcontract the services of any Respiratory Therapist or Physician? ❑ Yes ❑ No

16. Are you a member of any Health Industry Association? ❑ Yes ❑ No. If Yes, which?
    (HIDA, JCAHCO, IMDA, other) _____
    _____
    _____

17. If a member of the Joint Commission on the Accreditation of Health Care Organizations, are you Certified?
    ❑ Yes ❑ No. If Yes, attach copy of latest certification.

Any other premises or operations exposures not stated in this application? ❑ Yes ❑ No. If Yes, attach a complete description and underwriting/rating information.

SCHEDULE OF HAZARDS

Loc. No.	Classification	Class Code	Premium Bases: (s) Gross Sales (p) Payroll (a) Area (c) Total Cost (t) Other	Terr.	Rate		Premium	
					Prem/ Ops	Products Comp Ops	Prem/Ops	Products Comp Ops

During the past five years, have any claims been made or suit brought against you because of alleged malpractice, error, mistake or premises accident in any manner out of applicant's operation? ❑ Yes ❑ No

If Yes, date:_____ Please explain: _____

During the past three years, has any company cancelled, declined, or refused similar insurance to the applicant? (Not applicable in Missouri.) ❑ Yes ❑ No. If Yes, explain: _____

Previous Insurer: Indicate premium and losses for past three years. Describe all losses.

YEAR	COMPANY	POL. #	OCCURRENCE OR CLAIMS MADE	PREMIUM	LOSSES PAID	LOSSES RESERVED	DESCRIPTION

This application does not bind the applicant nor the Company to complete the insurance, but it is agreed that the information contained herein shall be the basis of the contract should a policy be issued.

APPLICABLE IN THE STATE OF NEW YORK:

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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

FRAUD WARNING

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.

NAME AND TITLE _____

APPLICANT'S SIGNATURE _____ Date _____

Name and Phone Number of individual to contact for inspection/audit _____

Agent Name _____ Agent License Number _____

(Applicable to Florida Agents Only.)

IMPORTANT NOTICE

As part of our underwriting procedure, a routine inquiry may be made to obtain applicable information concerning character, general reputation, personal characteristics and mode of living. Upon written request, additional information as to the nature and scope of the report, if one is made, will be provided