SCOTTSDALE
SURPLUS LINES INSURANCE COMPANY
8877 N Gainey Center Drive • Scottsdale, Arizona 85258
1-800-423-7675 • Fax (480) 483-6752
www.scottsdaleins.com

Medical Equipment Supply Stores Application

Applicant's Name _____
Mailing Address _____
_____
Location #1 _____
Complete a separate application for each location
Web Site Address _____

Agency Name _____
Agent _____
Address _____
_____
E-Mail _____
Phone _____

PROPOSED EFFECTIVE DATE: From _____ **To** _____ **12:01 A.M., Standard Time at the address of the Applicant**

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

Number of years in business: _____

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)		$	$
Errors and Omissions	Each claim	$	Errors and Omissions
	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.:..... _____%
   Do you sell vitamins or nutritional supplements under your own label? ..... ☐ Yes ☐ No

6. Do you sell or rent 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
   Do you deliver equipment? ..... ☐ Yes ☐ No
   If yes, how often? _____
   _____
   Do you do any construction or installation?..... ☐ Yes ☐ No
   If yes, explain: _____
   _____

9. Do you subcontract repair or installation operations?..... ☐ Yes ☐ No
   If yes, do you obtain Hold Harmless Agreements from your subcontractors?..... ☐ Yes ☐ No
   Minimum limits required of subcontractors: $_____

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	☐ Resuscitation equipment
☐ Apnea monitors	☐ Kidney machines	☐ Scooters/Tricarts
☐ Audiometers	☐ Latex gloves	☐ Stair lifts
☐ Beds, crutches, walkers, commodes	☐ Low air loss mattress	☐ Suction or Irrigation apparatus
☐ Cardiac Defibrillators	☐ Metal & foreign body locators	☐ TENS units
☐ Diathermy machines	☐ Nebulizers	☐ Ventilators
☐ Internal therapy	☐ Oscilloscopes	☐ Wheelchairs
☐ EKG machines	☐ Parenteral therapy	☐ Wheelchair lifts
☐ Heart Monitoring	☐ Radiation therapy	☐ X-ray, fluoroscopy

If you do sell latex gloves, who manufactures them? _____

Where is the manufacturer located? _____

Are the gloves purchased from a U.S. based distributor? ☐ Yes ☐ No

14. Do you directly import any foreign manufactured equipment? ☐ Yes ☐ No

If yes, provide details: _____

Do you manufacture orthopedic, ambulation or prosthetic devices? ☐ Yes ☐ No

If yes, provide details: _____

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

Do you employ any certified professionals? ☐ Yes ☐ No

If yes, explain: _____

16. Provide breakdown of annual receipts:

	SALES	RENTAL	SERVICE
Expendable items (bandages, tape, gauze, dressing, etc.)			
Non-expendable items (IV stands, traction apparatus, walkers, crutches, surgical instruments (non-critical), Prosthetic devices, etc.)			
Retail Pharmaceuticals			
Oxygen Equipment sales and rental (air compressors, oxygen concentrators, oxygen (liquid), etc.)			
Electric Wheelchairs and Scooters			
Diagnostic or Treatment Devices (CT scanners, MRIs, X-Ray equipment, EKG machines, IV pumps, blood pressure gauges, etc.)			
Ambulatory Equipment (manual wheelchairs, van lifts, stairlifts, hand control devices, etc.)			
Life Sustaining, Invasive or Critical Monitoring (Dialysis, heart/lung machines, apnea monitors, ventilators, incubators, medical gas systems, life-function monitoring, etc.)			
Home Infusion (distribution of drugs, nutrients, chemotherapy, etc.)			

17. Are you a member of any Health Industry Association? ☐ Yes ☐ No

If yes, which (HIDA, JCAHCO, IMDA, other): _____

18. 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

19. Do you have other business ventures for which coverage is not required? ☐ Yes ☐ No

If yes, explain and advise where insured: _____

20. During the past five years, have any claims been made or suits been 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: _____

21. During the past three years, has any company canceled, declined, or refused similar insurance to the applicant? (Not applicable in Missouri) ☐ Yes ☐ No

If yes, explain: _____

Previous Insurer and Loss History: Indicate all claims or losses (regardless of fault and whether or not insured) or occurrences that may give rise to claims for the prior three years. ☐ See loss run attached

YEAR	COMPANY	POLICY NO.	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.

APPLICANT'S SIGNATURE: _____ DATE: _____

NAME AND TITLE: _____

AGENT NAME: _____ AGENT LICENSE NUMBER: _____

(Applicable to Florida Agents Only.)

IOWA LICENSED AGENT: _____

NAME AND PHONE NUMBER OF INDIVIDUAL TO CONTACT FOR INSPECTION/AUDIT: _____

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.