

- Western World Insurance Company
- Tudor Insurance Company
- Stratford Insurance Company

Application
For
**Medical Equipment (DME)
Sales/Rental/Lease**

1. Name of Applicant _____
 Street Address _____
 City _____ State _____ Zip _____
 Applicant's Web Site Address _____

2. Individual Corporation Partnership Other (Explain) _____

3. List full names of individuals or partners and their interests: _____

4. Location of premises/operations (If same as above, write "Same") _____
 Street Address _____
 City _____ State _____ Zip _____

5. Date Established: _____

6. Provide the following information. If no prior insurance, check here.

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

7. Effective Dates Desired: From: _____ To: _____

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 \$ _____
 Fire Damage Limit (up to \$50,000 limit available) \$ _____ any one (1) fire
 Medical Expense Limit (up to \$5,000 limit available) \$ _____ any one (1) person
 Each Professional Incident Limit (if applicable) \$ _____

8. Premises Exposure
 Building _____ ACV/RC _____ Co. Ins. _____
 Contents _____ ACV/RC _____ Co. Ins. _____
 Bus Income _____ EE _____
 Construction of Building? _____ Number of Floors? _____
 Age of Building? _____ Sprinklered? _____
 Central Alarm? _____
 Protection Class 1-8 _____
 Protection Class 9 & 10 _____
 Area (square footage)? _____

9. **Product Information**

CHECK-OFF ITEMS BEING SOLD, RENTED OR LEASED:

	Do you carry?		Rent or Sales		Do you install?	
	Yes	No			Yes	No
1. Apnea Monitors	_____	_____	_____	_____	_____	_____
2. Arterial Pressure Monitors	_____	_____	_____	_____	_____	_____
3. Anesthesia Equipment	_____	_____	_____	_____	_____	_____
4. Blood Gas Analyzing Equipment	_____	_____	_____	_____	_____	_____
5. Bi-Paps	_____	_____	_____	_____	_____	_____
6. C-Paps	_____	_____	_____	_____	_____	_____
7. Cardiac Output Machine	_____	_____	_____	_____	_____	_____
8. Defibrillators	_____	_____	_____	_____	_____	_____
9. Grab Bars	_____	_____	_____	_____	_____	_____
10. IPPB	_____	_____	_____	_____	_____	_____
11. Infusion Therapy Equipment	_____	_____	_____	_____	_____	_____
Please circle equipment – (Enteral-Parenteral Chemotherapy-Antibiotic Therapy-Chemotherapy-Antibiotic foods-disposable tubing)						
12. Intensive Care Incubators	_____	_____	_____	_____	_____	_____
13. Laser Equipment	_____	_____	_____	_____	_____	_____
14. Life Function Monitoring	_____	_____	_____	_____	_____	_____
15. Medical Gas Piping System	_____	_____	_____	_____	_____	_____
16. Oxygen Equipment	_____	_____	_____	_____	_____	_____
Sub-Contract <input type="checkbox"/> Yes <input type="checkbox"/> No / Do you follow standard suppliers procedures <input type="checkbox"/> Yes <input type="checkbox"/> No						
17. Pace Makers	_____	_____	_____	_____	_____	_____
18. Resuscitators	_____	_____	_____	_____	_____	_____
19. Small Volume Nebulizers	_____	_____	_____	_____	_____	_____
20. Stair Lifts	_____	_____	_____	_____	_____	_____
21. Transcutaneous Nerve Stimulators	_____	_____	_____	_____	_____	_____
22. Ventilators – Life Support	_____	_____	_____	_____	_____	_____
23. Vertical (hoyer) Lifts	_____	_____	_____	_____	_____	_____
24. Wheel Chairs – Standard	_____	_____	_____	_____	_____	_____
25. Wheel Chairs - Power	_____	_____	_____	_____	_____	_____
26. Wheel Chair – Lifts	_____	_____	_____	_____	_____	_____
27. Motorized/Electrical Scooters	_____	_____	_____	_____	_____	_____
28. X-Ray Equipment	_____	_____	_____	_____	_____	_____
29. Other-Specify-Attach Listing	_____	_____	_____	_____	_____	_____

CHEMOTHERAPY

30. Prepare Drugs	_____	_____	Position	_____	Employed	_____	Sub-Contractor	_____
31. Administer Drugs	_____	_____	Position	_____	Employed	_____	Sub-Contractor	_____
32. Training for use of Equipment	_____	_____	Position	_____	Employed	_____	Sub-Contractor	_____

Closed Pharmacy (Only) –Not open to general public please list all compounds prepared:

A) _____ B) _____ C) _____

* Attach Brochure

Professional Liability Information

10. If you use certified professionals, please state number of professionals by category

	Employed	Contracted
Respiratory Therapist	_____	_____
Nurses	_____	_____
Orthotics	_____	_____
Prosthetics	_____	_____
Other	_____	_____
Description	_____	_____

Do you always verify licensing/certification? Yes No
 Do they carry their own GL Liability Insurance? Yes No
 Do they carry their own Prof. Liability Insurance? Yes No
 Do you require annual Certificates of Insurance? Yes No
 What limits do they carry? \$ _____

11. 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. \$ _____

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

13. What foreign-made products are sold? Please list. _____

14. Any sales of used equipment? Gross sales. Yes No \$ _____
 Specify types. _____

15. Describe any sales outside the U.S. Gross sales. \$ _____

16.

Additional Insureds	Interests	Do you require certificates?

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 subjects such person to criminal and civil penalties.

Applicant's Signature: _____ Date: _____

Title: _____ Producing Agent _____