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| Healthcare/Miscellaneous Facilities Liability Application |
| Durable Medical Equipment Supplement |
| * Ace American Insurance Company
* Illinois Union Insurance Company
* Westchester Surplus Lines Insurance Company
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**Instructions:**

The requested information is necessary before a quotation can be obtained.

Type or print clearly.

Answer ALL questions completely, leaving no blanks. If any questions, or part thereof, do not apply, print “N/A” in the appropriate space. Any spaces left blank will be interpreted to not apply.

Provide any supporting information on a separate sheet and reference the applicable question number.

Use 🗷 for Yes or No answers and other selections.

This application must be completed, dated and signed by an authorized representative of the applicant. Underwriters will rely on all statements made in this application.

The information requested in this application is for underwriting purposes only and does not constitute notice to the Company under any Policy of a claim or potential claim. All such notices must be submitted to the Company pursuant to the terms of the Policy, if and when issued.

***Notice*: This supplement is part of the main Healthcare/Miscellaneous Liability Application and is subject to the same warranties, representations and conditions. All relevant sections of the main application also apply to, and shall contemplate, applicants subject to this supplement. This includes but is not limited to the main application sections for Loss Experience, Coverage Requested, Exposures (prospective and historical Professional Liability, General Liability, Home Health Care and/or Hospice Services, Staffing Agency Services, Aircraft Liability, Automobile Liability, Watercraft Liability, and Employer’s Liability), Excess Liability, Professional Employees and Staff, License/Certification Information, Risk Management, Employment Practices, Previous Insurance, Prior Acts Warranty (if applicable), Fraud Warning, Declaration & Certification, and Signature.**

# Section A. – General Information

1. Legal name of the parent entity to be first named insured exactly as it shall be shown on the policy.

|  |  |
| --- | --- |
| First Named Insured | Street Address |
|       |       |
| City, State, Zip Code | County |
|       |       |

1. Please provide the following information:

|  |  |  |
| --- | --- | --- |
|  | Previous Year | Upcoming Year |
| Total Annual Gross Revenue: |       |       |
| Total receipts from Retail: |       |       |
| Total receipts from Rentals: |       |       |
| Total receipts from Wholesale: |       |       |
| Total receipts from Professional Services: |       |       |
|  |  |
| 1. Do these revenue figures include pharmaceuticals
 | Yes [ ]  No [ ]  |
| 1. State the amount of revenue generated from the sale or lease of medical supplies and/or equipment in the following categories
 |
| Category | Previous Year | Upcoming Year |
| I: Expendable Items |       |       |
| II: Non-Expendable Items |       |       |
| III: Diagnostic or Treatment Devices |       |       |
| IV: Life Sustaining or Critical Life Monitoring Equipment or Devices |       |       |
| 1. Is the applicant named as an Additional Insured-Vendor on the manufacturer’s policy for ALL products?
 | Yes [ ]  No [ ]  |
| 1. If no to question 4, is the applicant named as an Additional Insured-Vendor on the manufacturer’s policy for SOME products?
 | Yes [ ]  No [ ]  |
| If yes, please list the products and the percentage of annual revenues generated from each:       |

# Section B. Safety Procedures

|  |  |
| --- | --- |
| 1. Does the applicant have a written quality control program?
 | Yes [ ]  No  |
| 1. Are all devices/equipment checked and documented as to their condition prior to release to customer?
 | Yes [ ]  No  |
| 1. Are written instructions for the use of the products provided to the user?
 | Yes [ ]  No  |
| If yes, are the instructions reviewed with and signed by the user? | Yes [ ]  No  |
| 1. Are serial numbers of finished products shown on shipment invoices and are complete records kept of inventory shipments?
 | Yes [ ]  No  |
| 1. Please describe your servicing and emergency program(s) for life sustaining and critical life monitoring devices
 |  |
| 1. Have any products sold or leased by the applicant ever been recalled?

If yes, please explain       | Yes [ ]  No  |
| 1. Does the applicant have procedures in place to determine if a product sold or leased has been recalled?

If yes, please describe the procedures:       | Yes [ ]  No  |
| Please describe the recall process:       |  |
| 1. Does the applicant distribute oxygen cylinders?
 | Yes [ ]  No  |
| If yes, are they pre-filled or filled on premises       |  |
| 1. When handling oxygen cylinders and related equipment, are proper sterilization and transportation protocols consistent with FDA and DOT guidelines observed
 | Yes [ ]  No  |

# Section C. Maintenance

|  |  |
| --- | --- |
| 1. Does the applicant perform any maintenance or repairs on equipment sold or leased?

If yes, to which categories of equipment does this apply? (I,II,III, or IV)       | Yes [ ]  No  |
| 1. Does the applicant regularly conduct preventative maintenance on all devices and equipment following a written quality control program?
 | Yes [ ]  No  |
| 1. Are all manufacturers’ recommendations followed in the maintenance and repair of equipment?
 | Yes [ ]  No  |
| 1. Are all repair technicians trained and certified by the manufacturer?
 | Yes [ ]  No  |
| 1. Does the applicant subcontract labor for the service or repair of any products?

If yes, to which categories of equipment does this apply? (I, II, III, IV)      If yes, do you obtain certificates of insurance from subcontractors | Yes [ ]  NoYes [ ]  No |

# Section D. Operations

|  |  |
| --- | --- |
| 1. Does the applicant have its own sales staff?

If yes, are they trained by the manufacturer? | Yes [ ]  NoYes [ ]  No |
| 1. Are certificates of insurance obtained from all suppliers?
 | Yes [ ]  No |
| 1. Does the applicant repair, service, sell, or lease used equipment of others?
 | Yes [ ]  No |
| 1. Does the applicant modify any product in any way from its intended use?

If yes, please explain:       | Yes [ ]  No |
| 1. Does the applicant re-package or re-label any products obtained from suppliers?
 | Yes [ ]  No |
| 1. Are manufacturers’ labels ever removed from products?
 | Yes [ ]  No |
| 1. Does the applicant import any devices or equipment from foreign manufacturers?

If yes, do the manufacturers maintain any U.S. locations? | Yes [ ]  NoYes [ ]  No |

**The Applicant warrants to the Company that all statements made in this supplement are true and complete and no material facts have been misrepresented or misstated in this supplement or have been concealed or suppressed.**

**The Applicant understands that this form** **is part of the main Healthcare/Miscellaneous Facilities Liability Application and is subject to the same warranties, representations and conditions**.

|  |  |
| --- | --- |
|  |  |
| Signature of Applicant | Date |
|       |       |
| Title |  |
|       |  |