

## ALLIED MEDICAL DURABLE MEDICAL EQUIPMENT SUPPLEMENTAL APPLICATION

### GENERAL INFORMATION:

1. Percentage of sales to the public: \_\_\_\_%      Percentage of sales to institutions: \_\_\_\_%
  2. Expendable Items: Intended for one time usage (i.e. adhesive tape, bandages, or hypodermic needles, etc.)  
Estimated receipts in the next 12 months:      \$ \_\_\_\_\_  
Actual receipts in the last 12 months:      \$ \_\_\_\_\_  
Any pharmaceutical product/solutions sales?       No  Yes  
If "Yes," what percentage of the above est. receipts will be pharmaceuticals? \_\_\_\_\_%
  3. Non-expendable Items: Excluding diagnostic or treatment equipment or devices. This category includes, but is not limited to hospital beds, bathroom safety bars, portable toilets patient lifts or hoists, traction apparatus, ambulatory aids such as walkers, strollers, canes, crutches, wheelchairs, prosthetic devices and IV stands, including medical and surgical instruments unless considered diagnostic or treatment, etc.  
Estimated receipts in the next 12 months:      \$ \_\_\_\_\_  
Actual receipts in the last 12 months:      \$ \_\_\_\_\_  
Any lease or rental of the above equipment?       No  Yes  
If "Yes," lease/rental of equipment equals:      \_\_\_\_\_% of the above estimated receipts
  4. Diagnostic or Treatment Devices: This category includes oxygen and other medical gases used in conjunction with respiratory therapy (excluding ventilators), treatment devices or equipment NOT used to sustain life or perform critical life monitoring functions. Also included are blood pressure gauges, IV pumps, portable EKG machines, or sending devices.  
Estimated receipts in the next 12 months:      \$ \_\_\_\_\_  
Actual receipts in the last 12 months:      \$ \_\_\_\_\_  
Any lease or rental of the above equipment?       No  Yes  
If "Yes," lease/rental of equipment equals:      \_\_\_\_\_% of the above estimated receipts
  5. Life Sustaining or Critical Life Monitoring Equipment or Devices: This category includes dialysis or heart/lung machines, apnea monitors, SIDS monitors or any other life dependent monitors or any other equipment or devices that malfunction /failure or improper function of which could result in death or serious deterioration in health condition.  
Estimated receipts in the next 12 months:      \$ \_\_\_\_\_  
Actual receipts in the last 12 months:      \$ \_\_\_\_\_  
Any lease or rental of the above equipment?       No  Yes  
If "Yes," lease/rental of equipment equals:      \_\_\_\_\_% of the above estimated receipts
  6. Have any of the products that you distribute ever been recalled?       No  Yes  
If "Yes," please explain: \_\_\_\_\_
  7. Is the applicant named as an Additional Insured-Vendor on the manufacturer's policy for:  
 ALL products       SOME products       NO products  
If for SOME products, list those products and the Annual Receipts for each: \_\_\_\_\_
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8. Are written instructions for the use of the products provided to the user?  No  Yes  
 If "Yes," are the written instructions reviewed with and required to be signed off by the user?  No  Yes
9. Do you modify any products in any way after their original manufacture?  No  Yes  
 If "Yes," please explain: \_\_\_\_\_
10. Do you repackage or relabel any items obtained from suppliers?  No  Yes  
 If "Yes," please explain: \_\_\_\_\_
11. Is any equipment sold with the applicant's label?  No  Yes  
 If "Yes," please explain: \_\_\_\_\_
12. Do you maintain a written quality control program?  No  Yes
13. Do you have your own sales staff?  No  Yes  
 If "Yes," are they trained by the manufacturer?  No  Yes
14. Are all devices and/or equipment checked and their condition documented prior to their release?  No  Yes
15. Is preventive maintenance performed on all equipment & devices according to a written schedule?  No  Yes
16. Do you repair or sell other people's used equipment?  No  Yes
17. Are serial numbers of the finished product shown on shipment invoices and complete records kept of inventory shipments?  No  Yes
18. Do you use the services of an EPA approved contractor to dispose hazardous waste materials?  No  Yes
19. Are any products flammable or explosive?  No  Yes  
 If "Yes," please explain: \_\_\_\_\_
20. Does applicant have any exposure to nuclear or radioactive materials?  No  Yes  
 If "Yes," please explain: \_\_\_\_\_
21. For life sustaining or critical life monitoring devices or equipment, describe the 24 hour service, 365 day/year program that exists: \_\_\_\_\_  
 \_\_\_\_\_
22. Do you distribute oxygen cylinders?  No  Yes  
 Are they pre-filled or do you fill them at your premises? \_\_\_\_\_
23. Do you follow F.D.A. and D.O.T. regulations for the sterilization and transportation of oxygen?  No  Yes

**MAINTENANCE AND/OR REPAIR OF EQUIPMENT— LEASED OR SOLD:**

24. Do you subcontract labor for installation, service or repair of any products?  No  Yes  
 If "Yes," describe what equipment this applies to: \_\_\_\_\_  
 \_\_\_\_\_  
 Please describe which types of equipment YOU perform maintenance or repairs on: \_\_\_\_\_  
 \_\_\_\_\_
25. Are manufacturer recommendations followed for all maintenance and repair of equipment?  No  Yes  
 If "No," please explain: \_\_\_\_\_
26. Are certificates of insurance obtained from those entities that proved the maintenance and repair Services?  No  Yes

**MAINTENANCE AND/OR REPAIR OF EQUIPMENT— LEASED OR SOLD (continued):**

27. What limits of liability do you require of these maintenance and/or repair subcontractors?\_\_\_\_\_

\_\_\_\_\_  
Additional Comments or Interests:\_\_\_\_\_

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**Please attach a brochure and/or list of equipment and supplies handled.**

\* 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, may be committing a fraudulent insurance act, and may be subject to a civil penalty or fine.

\* not applicable in all states

**DECLARATION AND SIGNATURE:**

The undersigned declares that to the best of his/her knowledge the statements in this application and its attachments are true. The company is hereby authorized to make any investigation and inquiry deemed necessary in regard to this application.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Sub-Producer

\_\_\_\_\_  
Title/Date

\_\_\_\_\_  
Producer

SIGNING THIS FORM DOES NOT BIND THE APPLICANT OR THE COMPANY OR THE UNDERWRITING MANAGER TO COMPANY THE INSURANCE. Application MUST be currently signed, completed and dated to be considered for quotation.