☐ **Scottsdale Insurance Company**
Home Office: One Nationwide Plaza
Columbus, Ohio 43215
Adm. Office: 8877 North Gainey Center Drive
Scottsdale, Arizona 85258

☐ **Scottsdale Indemnity Company**
Home Office: One Nationwide Plaza
Columbus, Ohio 43215
Adm. Office: 8877 North Gainey Center Drive
Scottsdale, Arizona 85258

☐ **Scottsdale Surplus Lines Insurance Company**
Adm. Office: 8877 North 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.

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.

FRAUD WARNING (APPLICABLE IN TENNESSEE AND WASHINGTON):

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

FRAUD WARNING 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.

APPLICANT'S NAME AND TITLE: ______________________________

APPLICANT'S SIGNATURE: ______________________________ DATE: ______________

(Must be signed by an owner, partner or executive officer)

PRODUCER'S SIGNATURE: ______________________________ DATE: ______________

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.