☐ **Scottsdale Insurance 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

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

MEDICAL EQUIPMENT SUPPLY STORES LIABILITY APPLICATION

Complete a separate application for each location.

Applicant's Name: _____

Mailing Address: _____

Location Address: _____

Agency Name: _____

Agent No.: _____

Address: _____

E-mail: _____

Phone No.: _____

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

ANSWER ALL QUESTIONS—IF THEY DO NOT APPLY, INDICATE "NOT APPLICABLE" (N/A)

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

Website Address: _____

E-mail Address: _____ **Phone No.:** _____

Limits Of Liability and Deductible Requested:

General Aggregate (other than Products/Completed Operations)		$
Products and Completed Operations Aggregate		$
Personal and Advertising Injury (any one person or organization)		$
Each Occurrence		$
Damage To Premises Rented To You (any one premise)		$
Medical Expense (any one person)		$
Errors and Ommissions Coverage (Must be equal to GL limits, subject to $1,000,000/$3,000,000 maximum.)	Each Claim Aggregate	$ $
Other Coverages, Restrictions, and/or Endorsements:		$
Deductible		$

1. **Number of years in business:** ..... _____

2. **Percentage of operations from sale of non-medical products, such as office furniture, printed materials (e.g., labels, charts, prescription forms), scales, etc.:** ..... _____ %

3. **Type of operation and annual sales:**

☐ Sale of Medical, Hospital and Surgical supplies ..... $_____

☐ Rental/leasing of home care products/equipment to consumers ..... $_____

☐ Rent-to-own of home care products/equipment to consumers ..... $_____

☐ Drugstore/Pharmacy ..... $_____

☐ Provider of in-home services ..... $_____

Describe: _____

_____

☐ Other ..... $_____

Describe: _____

_____

4. **Additional Insured Information:**

Name	Address	Interest

5. **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, stair chair lifts, pool lifts, 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.)			

6. **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

7. **Percentage of equipment sold or leased/rented which is physician prescribed:** ..... _____ %

8. **Any sale of vitamins or nutritional supplements under applicant's own label?** ☐ Yes ☐ No

9. **Any sale or rental of oxygen and/or respiratory equipment, such as oxygen concentrators, cylinders and aspirators?** ☐ Yes ☐ No
   If yes, percentage of total operation: _____%
   Any refilling of oxygen (or other gases)? ☐ Yes ☐ No
   If yes, receipts: $_____

10. **Any sale or rental of any other gases?** ☐ Yes ☐ No
    If yes, describe: _____

11. **Does applicant buy or sell used equipment?** ☐ Yes ☐ No
    Percentage of total operation: _____%
    If yes, does applicant recondition/repair, prior to resale? ☐ Yes ☐ No
    Does applicant sell "as is"? ☐ Yes ☐ No
    Does applicant deliver equipment? ☐ Yes ☐ No
    If yes, how often? _____

12. **Does applicant do any construction or installation?** ☐ Yes ☐ No
    If yes, explain: _____

13. **Any vehicle chair lift installation, service or repair?** ☐ Yes ☐ No
    If yes, receipts: $_____

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

15. **Is equipment maintenance performed and documented according to manufacturers guidelines?** ☐ Yes ☐ No

16. **Are customers given any applicable Material Data Safety Sheets prepared by the equipment manufacturer?** ☐ Yes ☐ No

17. **What are your procedures for reporting any malfunctioning devices to the Federal Drug Administration?**

18. **Sale, rental or leasing of any of the following equipment or machines? Indicate by "x."**

☐ Anesthesia apparatus	☐ Intravenous	☐ Resuscitation equipment
☐ Apnea monitors	☐ Kidney machines	☐ Scooters/Tricarts
☐ Audiometers	☐ Laser medical devices	☐ Stair chair lifts
☐ Beds, crutches, walkers, commodes	☐ Latex gloves	☐ Suction or Irrigation apparatus
☐ Cardiac defibrillators	☐ Low air loss mattress	☐ TENS units
☐ Diathermy machines	☐ Metal and foreign body locators	☐ Ventilators
☐ Internal therapy	☐ Nebulizers	☐ Wheelchairs
☐ EKG machines	☐ Oscilloscopes and monitoring devices	☐ Wheelchair lifts
☐ Heart monitoring	☐ Parenteral therapy	☐ X-ray, fluoroscopy
☐ Inhalation therapy machines	☐ Radiation therapy	

If you sell latex gloves, who manufactures them? _____

Where is the latex gloves manufacturer located? _____

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

19. Does applicant directly import any foreign manufactured goods or equipment? ☐ Yes ☐ No

If yes, provide details: _____

20. Does applicant manufacture any goods or equipment? ☐ Yes ☐ No

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

If yes, provide details: _____

21. Does applicant employ or subcontract the services of any Respiratory Therapist or Physician? ☐ Yes ☐ No

Do you employ any certified professionals? ☐ Yes ☐ No

If yes, explain: _____

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

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

23. 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.

24. Any other premises or operations exposures not stated in this application? ☐ Yes ☐ No

If yes, attach a complete description and underwriting/rating information.

25. Does risk engage in the generation of power, other than emergency back-up power, for their own use or sale to power companies? ☐ Yes ☐ No

If yes, describe: _____

26. Does applicant have any other business ventures for which coverage is not required? ☐ Yes ☐ No

If yes, explain and advise where insured: _____

27. During the past five years, have any claims been made or suits been brought against you because of alleged malpractice, error or mistake? ☐ Yes ☐ No

If yes, date(s): _____

Please explain: _____

28. 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: _____

29. Schedule Of Hazards:

Loc. No.	Classification Description	Class. Code	Exposure	Premium Basis (s) Gross Sales (p) Payroll (a) Area (c) Total Cost (t) Other

30. Prior Carrier Information:

	Year:	Year:	Year:	Year:	Year:
Carrier					
Policy No.					
Coverage					
Occurrence or Claims Made					
Total Premium					

31. 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 five years. ☐ Check if no losses last five years.

Date of Loss	Description of Loss	Amount Paid	Amount Reserved	Claim Status (Open or Closed)

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. (Not applicable in AL, CO, DC, FL, KS, LA, ME, MD, MN, NE, NY, OH, OK, OR, RI, TN, VA, VT or WA.)

NOTICE TO ALABAMA APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

NOTICE TO COLORADO APPLICANTS: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

WARNING TO DISTRICT OF COLUMBIA APPLICANTS: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

NOTICE TO FLORIDA APPLICANTS: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

NOTICE TO KANSAS APPLICANTS: Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; 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.

NOTICE TO LOUISIANA APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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

NOTICE TO MARYLAND APPLICANTS: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO MINNESOTA APPLICANTS: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NOTICE TO OHIO APPLICANTS: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

NOTICE TO OKLAHOMA APPLICANTS: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

NOTICE TO RHODE ISLAND APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

FRAUD WARNING (APPLICABLE IN VERMONT, NEBRASKA AND OREGON): Any person who intentionally presents a materially false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

FRAUD WARNING (APPLICABLE IN TENNESSEE, VIRGINIA 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.

NEW YORK 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 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 STATEMENT:

I have read the above application and I declare that to the best of my knowledge and belief all of the foregoing statements are true, and that these statements are offered as an inducement to us to issue the policy for which I am applying. (Kansas: This does not constitute a warranty.)

APPLICANT'S SIGNATURE: _____ DATE: _____

CO-APPLICANT'S SIGNATURE: _____ DATE: _____

PRODUCER'S SIGNATURE: _____ DATE: _____

AGENT NAME: _____ AGENT LICENSE NUMBER: _____
(Applicable to Florida Agents Only)

IOWA LICENSED AGENT: _____
(Applicable in Iowa Only)

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.