



VGM Insurance PO Box 1328 – Waterloo, IA 50704
Overnight address: 1111 W. San Marnan Dr – (50701)
800-362-3363 Fax# 319-235-6656

Products/Completed Operations, Professional and/or
General Liability Insurance for HME Dealer, Pharmacy & Sleep Lab

VGM MEMBER# _____ Website _____

Proposed Effective Date: _____

Named Insured (full name of all companies to be insured under this policy):

DBA: _____

Street: _____

P.O. Box: _____

City: _____ State: _____ Zip Code: _____

Contact Person: _____ **Email:** _____

Phone#: _____ Fax# _____

FEIN: _____ Medicare Provider No.: _____

NPI No.: _____

Entity is: Corporation Individual Partnership Limited Partnership LLC Other _____

1. How many years experience in field? _____

2. How many years operating under same company name? _____

3. Are you a subsidiary of another entity or do you have any subsidiaries Yes No

If yes, please explain _____

4. Have you ever carried insurance that was written on a "claims made" basis? Yes No

If Claims Made – Retro Date: ____/____/____

5. Limit of Liability requested: \$300,000/\$300,000 \$500,000/\$500,000 \$1Mil/\$1Mil

\$1Mil/\$2Mil \$1Mil/\$3Mil \$2Mil/\$3Mil \$2Mil/\$4Mil \$3Mil/4Mil

\$4Mil/4Mil \$5Mil/\$5Mil

Gross Revenue

Estimated Annual Gross Receipts for the Upcoming Year: \$ _____

Previous Year: \$ _____

Inventory (products sold or rented or services rendered)

Gross Revenue must be broken into percentages and must equal 100%

Equipment Sales/Rentals:		Wheelchairs _____ %	Services:	_____ %
Apnea Monitor _____ %	Wheelchair Lifts _____ %	_____ %	Sleep Study _____ %	_____ %
Liquid Oxygen _____ %	_____ %	_____ %	Pharmacy _____ %	_____ %
Oxygen Cylinder _____ %	Braces _____ %	_____ %	Repair & Service _____ %	_____ %
Parenteral Therapy _____ %	CPAP _____ %	_____ %	Other Svc. (please list) _____ %	_____ %
Scooters/TriCarts _____ %	Grab/Safety Bars _____ %	_____ %		
Ventilators _____ %	ADLs _____ %	_____ %	Permanent Installation*:	
Defibrillators _____ %	Latex Gloves _____ %	_____ %	Elevators _____ %	_____ %
Diabetic Shoes _____ %	LAL Mattress _____ %	_____ %	Ramps _____ %	_____ %
	Nebulizers _____ %	_____ %	Ceiling Lifts _____ %	_____ %
Beds, Walkers, Crutches _____ %	TENS _____ %	_____ %	Stair Lifts _____ %	_____ %
CPM's _____ %	Uniforms _____ %	_____ %	Wheelchair Lifts _____ %	_____ %
Enteral Therapy _____ %	Diabetes Monitoring _____ %	_____ %	Hand Controls in Autos _____ %	_____ %
Lift Chairs _____ %	Diabetes Testing _____ %	_____ %	Wheelchair Lifts in Autos _____ %	_____ %
Motorized Wheelchairs _____ %	Disposables _____ %	_____ %	Grab Bars _____ %	_____ %
Oxygen Concentrators _____ %	Other _____ %	_____ %	Other Permanent Install _____ %	_____ %
Stair/Ceiling Lifts _____ %		_____ %		

"Installation of fixtures and equipment" means the permanent installation of equipment and fixtures attached to, or a part of, any building, structure or auto.

6. Do you customize, modify or repair any products? Yes No

If yes, which items? _____

7. Are you accredited by JCAHO, CHAP, ACHC, HQAA, CEAC? Please circle if applicable

8. Do you use any independent contractors for your business (1099's)? Yes No

If yes, in what capacity? _____

9. Do you employ contract or subcontract labor for installation, service or repair of products? Yes No

If yes, which products? _____

10. Do you sell or rent products or provide services to hotels, resorts, casinos or other retailers (i.e.: Wal-Mart, Kmart, etc.)? Yes No

If yes, please list businesses _____

11. Do you draw plans, designs, or specifications for any products sold? Yes No

If yes, which products? _____

12. Do you manufacture any products? Yes No

13. Do you provide warranties or guarantees other than those provided by manufacturers? Yes No

14. Please check if you would like a quote for:

Hired and/or Non-Owned Auto¹ \$250,000 limits

Employee Benefits Liability² \$1,000,000 limits

¹Supplemental Application Required

²Number of employees _____

Professional Liability

15. Please state number of certified professionals by category:

Respiratory Therapists _____ Nurses _____ Pharmacists _____ Occupational/Physical Therapists _____

Describe their function:

16. Do you charge a fee for respiratory therapy services separate from the sale or rental of equipment?

Yes No

17. Do Pharmacists carry their own individual professional policy? Yes No

18. Is the pharmacy owner a registered pharmacist? Yes No

19. Are tests administered by a certified Polysomnographic Technologist (PST)? **Yes** **No**

20. Do you employ a medical director? **Yes** **No** Medical director's name: _____

Prior Liability Insurance Experience

Carrier Name _____ Year: _____ Premium: _____

Carrier Name _____ Year: _____ Premium: _____

21. Have there been any claims filed or losses paid, **or** are you aware of any incidents which might give rise to a suit against you, within the last three (3) years?

Yes No If yes, please describe below or attach sheet or prior carrier loss history

Location Information

Main Location

Bldg Address: _____

Square Feet: _____ Own Lease

Location #2

Bldg Address: _____

Square Feet: _____ Own Lease

Location #3

Bldg Address: _____

Square Feet: _____ Own Lease

The Warranties following will be made a part of any policy issued under this program.

WARRANTED: The Company named on the front hereof and as signed below does not engage in any of the following activities:

- A. Manufacture of any product.
- B. Re-Manufacture or re-building of any item (repairs allowed – see below)
- C. Provide home health nursing, therapy or other medical or quasi-medical services of any kind.
- D. Charge a fee for medically related services.
- E. Sell or rent significant volumes of imported product (significant is deemed to be in excess of 5%)
- F. Directly import any product.

WARRANTED: The Company named on the front hereof and as named below will adhere to the following quality criteria to be eligible for (and remain eligible for) coverage under this insurance program:

- A. Repair work allowed on owned or rented equipment only, by trained personnel and following manufacturers recommendations. No significant outside repair work is allowed.
- B. The insured provides no express or implied warranties of mercantability, fitness for use, or safety other than those warranties insured is expressly authorized to provide as an agent on behalf of the manufacturer, by the manufacturer.
- C. If oxygen is offered a true 24-hour service program must exist.
- D. Insured must have and designate a "Safety Manager" to receive, catalog and disseminate all safety and loss control information.
- E. No injections or I.V. administration may be done by an insured unless the individual so doing is properly licensed and the administration is incidental to the sale or rental of the equipment and not on a fee basis.
- F. Permanent installation of equipment must be disclosed and specifically approved by Insurer.
- G. Customer agrees to no leasing or rental of equipment in off premises retail locations (malls, large retailers, hotels, resorts, casinos, etc.) without direct involvement of employed or subcontracted staff at the delivery point.

WARNING!! This is an important document, which could affect your legal rights. Please **read it again carefully** and **be certain it is correct and complete**. Your signature below is your warranty to us that we can rely on this form. We have made no investigation of our own and the coverage decision will be based on this information. **COVERAGE IS NOT BOUND OR STARTED BY THIS FORM. WE MAKE NO PROMISE TO INSURE. THIS IS ONLY A REQUEST FOR A QUOTE. YOU ARE NOT COVERED UNTIL AND UNLESS YOU RECEIVE A BINDER SO STATING.**

The coverages that we are quoting from information on this form are Product/Completed Operations & Professional and/or General Liability Insurance. We base important decisions on your answers to these questions. We rely on the accuracy of your answers. If you have any questions about the form or your answers please ask your sales representative.

The questions in this application are not intended to, nor do they, indicate the existence, non-existence or limitations on any items of coverage. This document does not in any fashion determine the coverage provided.

INCOMPLETE APPLICATIONS WILL BE REJECTED

Signature and Attestation:

Name (Print): _____

Return To:

Signature: _____

VGM Insurance

Title: _____

Date: _____/_____/_____