



Please visit our website:
vgminsurance.com
or call us at: 800-362-3363

Products/Completed Operations
Professional and General Liability Insurance for
ORTHOTIC & PROSTHETIC FACILITIES

OPGA/POINT MEMBER# _____

Proposed effective date for this insurance: _____

Named Insured (full name of all companies as they are to appear in the policy):

DBA: _____

Street: _____ P.O. Box: _____

City: _____ State: _____ Zip Code: _____

Contact Person: _____ Email: _____

Phone#: _____ Fax#: _____

FEIN: _____ Medicare Provider Number: _____

NPI No.: _____

Entity is: Corporation Individual Partnership Limited Partnership LLC Other _____

1. How many years in the 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. Limit of Liability requested:
Please check one:
[] \$500,000
[] \$1,000,000 - \$1,000,000
[] \$1,000,000 - \$2,000,000
[] \$1,000,000 - \$3,000,000
[] \$2,000,000 - \$3,000,000
[] \$2,000,000 - \$4,000,000
[] \$3,000,000 - \$4,000,000
[] \$4,000,000 - \$4,000,000
[] \$5,000,000 - \$5,000,000

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

Previous Year: \$ _____

Gross Revenue Sources:

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

PATIENT CARE SALES: Includes all sales of items you make, fit or alter for individual patients	%
SUPPLIER/DISTRIBUTOR: Includes all items purchased from others that you resell to another facility or distributor	%
SUPPLIER/MANUFACTURER: No patient contact. Includes items manufactured by you and sold to facilities (central fabrication)	%
DME – DURABLE MEDICAL EQUIPMENT & SOFT GOODS: Includes items sold or rented directly to patients with no altering or re-labeling of parts. Includes pharmacy Rx, OTC and disposables.	%

5. Do you use any independent contractors for your business (1099) Yes No
6. Do you employ contract or subcontract labor for service or repair of products? Yes No
7. Do you render professional services directly to patients without physician referral? Yes No
8. Do you perform or assist in any surgical procedures? Yes No
9. 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 (Please attach prior carrier loss history)

If you answered **yes** to any of the questions above, please explain:

10. 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

11. Please indicate the number of professionals in each category:

a) ABC or BOC Certified Prosthetists/Orthotists _____

b) Fitters _____ c) Pedorthists _____ d) Physical Therapists _____

Prior Liability Insurance Experience

Carrier Name _____ Year: _____ Premium: _____

Carrier Name _____ Year: _____ Premium: _____

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

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

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 FOLLOWING WARRANTIES WILL BE MADE A PART OF ANY POLICY ISSUED UNDER THIS PROGRAM.

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 WITH 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 coverage that we are quoting from information on this form is Product/Completed Operations & Professional and/or General Liability Insurance. 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 of coverage.

INCOMPLETE APPLICATIONS WILL BE REJECTED

Signature and Attestation: _____

Return via fax or email to:

VGM Insurance

PO Box 1328

Waterloo, IA 50701

FAX: 319-235-6656

Email: john.boardsen@vgm.com or david.oleson@vgm.com

Name (Print): _____

Signature: _____

Title: _____

Date: _____