1111 W. San Marnan Drive
P.O. BOX 1328
WATERLOO, IA 50704
PHONE: 800-362-3363 FAX: 319-235-6656

ORTHOTIC AND PROSTHETIC FACILITIES
General Liability and Professional Application

OPGA/POINT MEMBER No. _____ **Proposed Effective Date** _____

LEGAL NAMED INSURED (full name of all companies to be insured under this policy)

_____

DBA _____

Entity is: ◯ S Corporation ◯ C Corporation ◯ Individual ◯ Partnership ◯ Limited Partnership ◯ LLC ◯ Other

Website _____

Mailing Address _____

Physical Address _____

City _____ State _____ ZIP _____ County _____

Contact Person _____ Email _____

Phone No. _____ Fax No. _____

FEIN _____ Medicare Provider No. _____

NPI No. _____ Unemployment No. _____

Would you like to receive a discount on your Medicare/Medicaid surety bond? ◯ **Yes** ◯ **No**

1. How many years of 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. Limit of Liability requested

   ☐ $500,000 ☐ $1Mil/$1Mil ☐ $1Mil/$2Mil
   ☐ $1Mil/$3Mil ☐ $2Mil/$3Mil ☐ $2Mil/$4Mil ☐ $3Mil/$4Mil
   ☐ $4Mil/$4Mil ☐ $5Mil/$5Mil

   Excess limits requested:

   ☐ $1Mil ☐ $2Mil ☐ $3Mil ☐ $4Mil ☐ $5Mil

Estimated Annual Gross Revenue for the Upcoming Year: $ _____

Previous Year: $ _____

Total Number of Employees _____

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 directly import any products or components? ◯ Yes ◯ No
6. Do you use any independent contractors for your business (1099)? ◯ Yes ◯ No
7. Do you employ contract or subcontract labor for service or repair of products? ◯ Yes ◯ No
8. Do you render professional services directly to patients without physician referral? ◯ Yes ◯ No
9. Do you perform or assist in any surgical procedures? ◯ Yes ◯ No
10. 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 five (5) years? ◯ Yes ◯ No

If yes, please provide a copy of your loss runs for the past five years.

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

_____

_____

_____

Please check if you would like a quote for:

☐ Hired and/or Non-owned Auto[1]

[1]Supplemental Application Required

☐ $1,000,000 limits

☐ Employee Benefits Liability[2] $ 1,000,000 limits

[2]Number of employees _____

*May not be available in all states

Professional Liability

11. Are you ABC or BOC Certified: ◯ Yes ◯ No
12. Please indicate the number of professionals in each category:

ABC or BOC Certified Prosthetists/Orthotists _____Fitters_____Pedorthists_____Physical Therapists_____

Prior Liability Insurance Experience

Carrier Name _____ Year _____ Premium _____

Carrier Name _____ Year _____ Premium _____

13. Have you ever carried insurance that was written on a "claims made" basis? ◯ Yes ◯ No
    If yes, please provide the retro date: _____/_____/_____

Location Information

Main Location

Building Address: _____

Square Feet: _____ ◯ Own ◯ Lease

Location #2

Building Address: _____

Square Feet: _____ ◯ Own ◯ Lease

Location #3

Building Address: _____

Square Feet: _____ ◯ Own ◯ Lease

Percentage of Revenue per Location

_____ %

_____ %

_____ %

FRAUD NOTICE STATEMENTS

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER 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 THE PERSON TO CRIMINAL AND CIVIL PENALTIES, IN ACCORDANCE WITH APPLICABLE LAW. IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF INJURING, DEFRAUDING OR DECEIVING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS, IN ACCORDANCE WITH APPLICABLE LAW. (AL, AR, CT, DE, FL, GA, HI, ID, IL, IN, IA, KS, KY, LA, MA, MD, ME, MI, MS, MO, MT, NE, NV, NH, NJ, NM, NC, ND, OH, OR, SC, SD, TN, TX, UT, VT, VA, WA, WV, WI, WY)

Applicable in Alaska
A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

Applicable in Arizona
For your protection Arizona law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is subject to criminal and civil penalties.

Applicable in California
For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Applicable in Colorado
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 policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder 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.

Applicable in the District of Columbia
WARNING: 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.

Applicable in Minnesota
A person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Applicable in 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.

Applicable in Pennsylvania
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.

Applicable in Rhode Island
The Department of Business Regulation requires us to inform you of your legal time to pursue a claim. The legal time limit is commonly referred to as the statute of limitations. In the state of Rhode Island, the statute of limitations for a property damage claim is ten (10) years, and three (3) years for a bodily injury claim. If you have any questions, please feel free to contact us.

THE UNDERSIGNED REPRESENTS THAT HE/SHE HAS MADE A GOOD FAITH EFFORT TO ASCERTAIN COMPLETE AND ACCURATE ANSWERS TO THE QUESTIONS SET FORTH IN THIS APPLICATION AND THAT THE INFORMATION PROVIDED IN THIS APPLICATION, INCLUDING ANY ATTACHMENTS, IS TRUE, ACCURATE AND COMPLETE TO THE BEST OF HIS/HER KNOWLEDGE AND BELIEF.

_____ _____

Name (Please print) Title (Must be President, Chairman, CEO or Director)

_____ _____

Signature Date

The above signed warrants that he/she is authorized and has the power to complete and execute this Application, including the Warranty Statement on behalf of the Applicant and the Applicant's respective Directors, Officers or other insured parties.