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

HME DEALERS, PHARMACIES AND SLEEP LABS

General Liability and Professional Application

VGM 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. _____

I would also like to receive a competitive quote for the following:

☐ Property ☐ Workers' Comp ☐ Cyber/Data Breach Liability
☐ Business Auto ☐ Employment Practices Liability ☐ Directors and Officers

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. Do you have any bankruptcies, tax or credit liens against you? ◯ Yes ◯ No

   _____

   (respond only if state law permits)
5. Have you ever carried insurance that was written on a "claims made" basis? ◯ Yes ◯ No
   If Claims Made – Retro Date _____/_____/_____
   Copy of claims-made policy DEC page required.

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

Are you a member of the American Association for Homecare? ◯ Yes ◯ No

Are you an NDC Homecare or Dedicated Distribution Member? ◯ Yes ◯ No

Payroll

Job Classification	Total Annual Payroll	# of Employees
Payroll of Inside Staff (Clerical/Retail)	$	
Payroll of Outside Staff (Salespersons/Delivery)	$	

Revenue – Estimated Annual Gross Receipts for Upcoming Year

Sales Receipts $ _____

Rental Receipts $ _____

Sales of Reprocessed, Reconditioned or Used Equipment $ _____

6. 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

Excess limits requested:

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

Inventory (Products Sold, Rented or Services Rendered)
Inventory below must be broken into percentages and must total 100% from all columns.

EQUIPMENT/SALES/RENTALS	Current Yr.		Current Yr.	**SERVICES**	Current Yr.
Apnea Monitor	%	Braces/Orthotics	%	Wound Therapy	%
Liquid Oxygen	%	CPAP/Bi-level PAP	%	Cold Therapy	%
Oxygen Cylinder	%	BiPAP	%	Patient Lifts	%
Parenteral Therapy	%	Grab/Safety Bars	%	Van Conversions	%
Scooters/TriCarts	%	Trapeze Bars	%	Wheelchair Ramps	%
Defibrillators	%	ADLs	%	Sleep Study	%
Diabetic Shoes	%	Latex Gloves	%	Pharmacy	%
Beds, Walkers, Crutches	%	LAL Mattresses	%	Repair and Service	%
CPMs	%	Nebulizers	%	Surgical Implants	%
Enteral Therapy	%	TENS	%	Other (please list)	%
Lift Chairs	%	Uniforms	%		
Motorized Wheelchairs	%	Diabetes Supplies	%	**PERMANENT INSTALLATION***	
Oxygen Concentrators	%	Disposables	%	Elevators	%
Stair/Ceiling Lifts	%	Rollators/Knee Walkers	%	Ramps	%
Medical Alert Systems	%	HME Misc. Equipment	%	Ceiling Lifts	%
Ventilators	%	Infusion Pump	%	Stair Lifts	%
Wheelchairs	%	Mastectomy Items	%	Wheelchair Lifts	%
Wheelchair Accessories	%	Other (please list)	%	Hand Controls in Autos	%
Wheelchair Lifts	%		%	Wheelchair Lifts in Autos	%
				Grab Bars	%
				Other (please list)	%

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

7. Do you customize, modify or repair any products? ◯ Yes ◯ No
   If yes, which items? _____
8. Are you accredited by: ☐ HQAA ☐ JCAHO ☐ CHAP ☐ ACHC ☐ CEAC Last accreditation date:_____
9. Do you use any independent contractors for your business (1099s)? ◯ Yes ◯ No
   If yes, in what capacity? _____
10. Do they carry their own individual coverage? ◯ Yes ◯ No
11. Please list any subcontractors (1099s) and describe their positions or duties within your company.
    Name: _____ Position:_____
    Name: _____ Position:_____
    Name: _____ Position:_____
    Do you collect certificates of insurance from these subcontractors? ◯ Yes ◯ No
12. Do you sell, lease or rent products or provide services to hotels, resorts, casinos or other retailers (e.g., big box stores, malls or grocery stores)? ◯ Yes ◯ No
    If yes, please list businesses and products provided _____

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

If yes, which products? _____

14. Do you directly import any products or components? ◯ Yes ◯ No

15. Do you private-label or have products made? ◯ Yes ◯ No

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

Professional Liability

17. Please state number of certified professionals by category:

RTs _____ Nurses _____ Pharmacists _____ OTs/PTs _____ Other _____

Describe their function _____

If any pharmacists, please complete pharmacy operations section on next page.

18. Do nurses, PT, RT or OT carry their own professional liability? ◯ Yes ◯ No

a. What limits do they carry? _____

b. Do you keep copies of certificates of insurance? ◯ Yes ◯ No

19. Do you charge a fee for professional services separate from the sale or rental of equipment? ◯ Yes ◯ No ◯ NA

20. Do you employ or contract a medical director? ◯ Yes ◯ No ◯ NA

Medical director's name _____

Prior Liability Insurance Experience

Carrier Name _____ Year _____ Premium _____

21. Have there been any claims filed or losses paid? ◯ Yes ◯ No **If yes, please provide copy of loss runs for 5 years.**

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 describe: _____

Location Information

Main Location	**Percentage of Revenue per Location**
Building Address: _____	_____ %
Square Feet: _____ ◯ Own ◯ Lease	
Location #2	
Building Address: _____	_____ %
Square Feet: _____ ◯ Own ◯ Lease	
Location #3	
Building Address: _____	_____ %
Square Feet: _____ ◯ Own ◯ Lease	

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 _____

*Not available in all states.

Pharmacy Operations, complete as applicable.

1. Do you operate a closed- or open-door pharmacy? ◯ Closed-door ◯ Open-door
2. If an open pharmacy, is there any other business exposure, such as gift shop, restaurant, etc.?

   Please describe: _____

   _____
3. Number of pharmacists on staff?_____

   Please list full- and part-time pharmacists and whether they have a professional liability policy.

   Attach separate sheet if needed.

   a._____ ◯ Yes ◯ No If yes, carrier _____

   b._____ ◯ Yes ◯ No If yes, carrier _____

   c._____ ◯ Yes ◯ No If yes, carrier _____
4. Is the pharmacy owner a registered pharmacist? ◯ Yes ◯ No

It is recommended that you maintain in your records a copy of a certificate showing proof of individual professional coverage for each full- and part-time pharmacist from an AM Best Excellent or better-rated carrier[1].

[1]There are a number of nationally recognized carriers who provide Pharmacists Individual Professional coverage. Please ask an agent at VGM for more information.

5. What is the gross revenue for OTC drugs? (aspirin, cold medicine, etc.) $ _____
6. What is the gross revenue for prescription drugs? $ _____
7. Are you compounding? ◯ Yes ◯ No If no, please skip to question 13.

   If yes, ◯ Sterile ◯ Non-Sterile

   a. If yes, are you section ◯ 503A (Traditional) or ◯ 503B (Outsourcing)

   b. If 503A, are you seeking 503B approval? ◯ Yes ◯ No
8. Are you PCAB Certified? ◯ Yes ◯ No

   If yes, are you ◯ Sterile Certified or ◯ Non-Sterile Certified?
9. Are you QCCP Certified? ◯ Yes ◯ No
10. Are you compounding in a clean room? ◯ Yes ◯ No
11. Are you compounding under a Laminar air flow hood? ◯ Yes ◯ No
12. Do you have an ambulatory suite? ◯ Yes ◯ No

    If yes, how many chairs? _____

13. Do you offer infusion therapy? ◯ Yes ◯ No If no, please skip to Sleep Studies section.

If yes, please indicate the services you provide:

☐ Anti-Infective Therapy	☐ Enteral Nutrition	☐ Parenteral Nutrition (TPN)
☐ Immune Therapy (Ig)	☐ Chemotherapy	☐ Pain Management
☐ Hydration	☐ Inotropic Therapy	☐ Specialty Injectables
☐ Alpha-1	☐ Factor	☐ Steroids
Other_____	Other_____	

14. What are your top three infusion therapies? _____

15. What is your average monthly infusion patient census? _____ Enteral patient census? _____

16. Do you employ nurses for infusion therapy? ◯ Yes ◯ No

If yes, how many? _____Describe duties: _____

_____

17. Do you employ or contract a PICC nurse? ◯ Yes ◯ No

If yes, how many full-time? _____Describe duties: _____

_____

18. Do you employ technicians for infusion therapy? ◯ Yes ◯ No

If yes, how many? _____

19. Are you hospital-based? ◯ Yes ◯ No

Sleep Studies, complete as applicable.

1. Who is interpreting or analyzing the results? Who employs this individual?

_____

2. Please describe the testing procedure:

_____

_____

3. Is there a fee for the service? ◯ Yes ◯ No

4. Are tests administered by a certified polysomnographic technologist (PST)? _____

Number of PSTs on staff? _____

5. Do you employ a medical director? ◯ Yes ◯ No Medical director's name _____

6. Where is the testing done? (please check all that apply)

☐ Patient's home ☐ HME facility ☐ Hospital ☐ Sleep lab

a. Please enclose a list of facility locations.

b. How many patients stay overnight at one time? _____

c. What is the ratio of staff to patients?_____

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.