INSURANCE INNOVATORS INCORPORATED
130 S. Easton Rd., Glenside, PA 19038 800-523-6422; 215-885-7300; 215-886-2482 fax
484 Schooleys Mountain Road, Suite 2, Hackettstown, NJ 07840 888-975-4637; 732-752-3388; 732-752-5677 fax
10430 Shaker Drive, Suite 200, Columbia, MD 21046 800-392-3771; 410-337-9295; 410-730-2156 fax

www.iiigroup.com

Medical Equipment (DME)
Sales/Rental/Lease

1. Name of Applicant _____
   Street Address _____
   City _____ State _____ Zip _____
   Website Address _____

2. ( ) Individual ( ) Corporation ( ) Partnership ( ) Other (Explain) _____

3. List full names of individuals or partners and their interests: _____
   _____

4. Location of premises/operations (If same as above, write "Same") _____
   Street Address _____
   City _____ State _____ Zip _____

5. Date Established: _____

6. Provide the following information. If no prior insurance, check here: ( )

Insurance Company	Policy Period	Limits of Liability	Premium	Type of Coverage Occurrence or Claims Made	# of Claims Each Year

7. Proposed Effective Date: _____ Proposed Exp. Date: _____

   LIMITS OF INSURANCE REQUESTED:
   General Aggregate Limit (Other than Products-Completed Operations) $ _____
   Products-Completed Operations Aggregate Limit $ _____
   Personal and Advertising Injury Limit $ _____
   Each Occurrence Limit $ _____
   Fire Damage Limit (up to $50,000 limit available) $ _____
   Medical Expense Limit (up to $45,000 limit available) $ _____
   Each Professional Incident Limit (if applicable) $ _____

8. Premises Exposure
   Building _____ ACV/RC _____ Co. Ins. _____
   Contents _____ ACV/RC _____ Co. Ins. _____
   Bus Income _____ EE _____
   Construction of Building _____ Number of Floors _____
   Age of Building _____ Sprinklered _____
   Central Alarm _____
   Protection Class 1-8 _____
   Protection Class 9 & 10 _____
   Area (square footage) _____

9. Product Information

CHECK OFF ITEMS BEING SOLD, RENTED OR LEASED:

		Do you carry?		Rent or Sales		Do you install?	
		Yes	No			Yes	No
1.	Apnea Monitors						
2.	Arterial Pressure Monitors						
3.	Anesthesia Equipment						
4	Blood Gas Analyzing Equipment						
5.	Bi-Paps						
6.	C-Paps						
7.	Cardiac Output Machine						
8.	Defibrillators						
9.	Grab Bars						
10.	IPPB						
11.	Infusion Therapy Equipment						
	Please circle equipment-(Enteral-Parenteral Chemotherapy-Antibiotic Therapy-Chemotherapy-Antibiotic Foods-Disposable Tubing)						
12.	Intensive Care Incubators						
13.	Laser Equipment						
14.	Life Function Monitoring						
15.	Medical Gas Piping System						
16.	Oxygen Equipment						
	Sub-Contract ( ) Yes ( ) No / Do you follow standard suppliers procedures ( ) Yes ( ) No						
17.	Pace Makers						
18.	Resuscitators						
19.	Small Volume Nebulizuers						
20.	Stair Lifts						
21.	Transcutaneous Nerve Stimulators						
22.	Ventilators-Life Support						
23.	Vertical (hoyer) Lifts						
24.	Wheel Chairs-Standard						
25.	Wheel Chairs-Power						
26.	Wheel Chair-Lifts						
27.	Motorized/Electrical Scooters						
28.	X-Ray Equipment						
29.	Other-Specify-Attach Listing						

CHEMOTHERAPY

30.	Prepare Drugs			Position		Employed		Sub-Contractor	
31.	Administer Drugs			Position		Employed		Sub-Contractor	
32.	Training for use of Equipment			Position		Employed		Sub-Contractor	

Closed Pharmacy (Only) – Not open to general public please list all compounds prepared:

A) _____ B) _____ C) _____

*Attach Brochure

Professional Liability Information

10. If you use certified professionals, please state number of professionals by category

	Employed	Contracted
Respiratory Therapist		
Nurses		
Orthotics		
Prosthetics		
Other		
Description		

Do you always verify licensing/certification? ( ) Yes ( ) No
Do they carry their own GL Liability Insurance? ( ) Yes ( ) No
Do they carry their own Prof. Liability Insurance? ( ) Yes ( ) No
Do you require annual Certificates of Insurance? ( ) Yes ( ) No
What limits do they carry? $ _____

11. Show separate gross sales for items sold, $ _____
Show separate gross sales for items rented/leased, $ _____
Total estimated gross sales for the upcoming year. $ _____
Show payroll for service or repair by employees. $ _____
Show cost for installation and repair work subcontracted. $ _____

12. Do manufacturers name you as Vendor/Additional Insured? ( ) Yes ( ) No
If yes, please attach Certificate of Insurance.

13. What foreign-made products are sold? Please list. _____
_____
_____

14. Any sales of used equipment? Gross sales. ( ) Yes ( ) No $ _____
Specify types. _____

15. Describe any sales outside the U.S. Gross sales. $ _____

16.	Additional Insureds	Interests	Do you require certificates?

FRAUD NOTICE: Any person who knowingly and with intent to defraud any insurance company files an application for insurance or statement of claim containing any materially false information or conceals for the purposes of misleading, information concerning any fact or material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Applicant's Signature _____ Date: _____

Title: _____ Producing Agent _____