



FLORIDA HOME MEDICAL EQUIPMENT
DEALER INSURANCE SURVEY

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General Information

Date of survey: _____ Insurance Renewal Date: _____

Legal Name of Organization: _____
(please include all organizations that are to be included as insureds)

FEIN: _____

Mailing Address: _____

County: _____

Telephone: _____ Fax: _____

Contact Name: _____ Contact Title: _____

Website Address: _____ E-Mail Address: _____

Insurance Agent Information

Agent's Name: _____

Name of Agency: _____

Address: _____

Agency telephone: _____ Agency fax: _____

Date proposal is needed: _____ Agency e-mail address: _____

Do you currently write this account? Yes No

If Yes, for how long? _____ With what Carrier? _____

Is the account Sub-Brokered? Yes No

If yes, please indicate Agency Name: _____

Business Information

Description of organization: Sole Proprietorship Partnership Corporation Other _____

Years in business _____ Years experience _____

If in Business for less than 3 years, please attach resume and summary of experience of Manager.

Number of Employees: _____ Number of Executives/Officers/Owners: _____ Is there an employee union? Yes No

Is your business a subsidiary or division of another company? Yes No

If yes, please provide the name of the company, the address and relationship: _____

Has your business had any changes in ownership over the past 3 years? Yes No

If yes, please provide details: _____

Has any insurance carrier cancelled, declined, or refused to renew any insurance within the past 3 years? Yes No

If yes, please provide dates, coverage, and explanation: _____

Property and Location Information

PROVIDE THE INFORMATION BELOW OR ATTACH AN ACORD PROPERTY APPLICATION

Current Carrier: _____ Current Premium: \$ _____

Loc . No.:		Address:			
Building Limit: \$		Personal Prop. Limit: \$		Occupancy Type:	
Construction Type: <input type="checkbox"/> Type 1-Frame <input type="checkbox"/> Type 2-Joisted Masonry <input type="checkbox"/> Type 3-Non-combustible <input type="checkbox"/> Type 4-Masonry non-combustible <input type="checkbox"/> Type 5-Modified fire resistive <input type="checkbox"/> Type 6-Fire resistive		Building Protection: (Check all that apply) <input type="checkbox"/> Local Alarm <input type="checkbox"/> Heat Detection <input type="checkbox"/> Other: _____ <input type="checkbox"/> Central Station Alarm <input type="checkbox"/> Smoke Detection <input type="checkbox"/> Burglar Alarm <input type="checkbox"/> Motion Detection <input type="checkbox"/> Fire Extinguishers <input type="checkbox"/> Security Guard/Service <input type="checkbox"/> Sprinklers (____%) <input type="checkbox"/> Cameras <input type="checkbox"/> Full Intrusion Perimeter Alarm			
Own/Lease:	Building Info:	Year:	Updated/Inspected	Additional Occupancies	
<input type="checkbox"/> Own	Number of Stories: _____	Roof: _____ / _____		_____	
<input type="checkbox"/> Lease	Building Sq. Ft.: _____	Plumbing: _____ / _____		_____	
	Sq. Ft. You Occupy: _____	Wiring: _____ / _____		_____	
	Year Built: _____	HVAC: _____ / _____		_____	
Loc . No.:		Address:			
Building Limit: \$		Personal Prop. Limit: \$		Occupancy Type:	
Construction Type: <input type="checkbox"/> Type 1-Frame <input type="checkbox"/> Type 2-Joisted Masonry <input type="checkbox"/> Type 3-Non-combustible <input type="checkbox"/> Type 4-Masonry non-combustible <input type="checkbox"/> Type 5-Modified fire resistive <input type="checkbox"/> Type 6-Fire resistive		Building Protection: (Check all that apply) <input type="checkbox"/> Local Alarm <input type="checkbox"/> Heat Detection <input type="checkbox"/> Other: _____ <input type="checkbox"/> Central Station Alarm <input type="checkbox"/> Smoke Detection <input type="checkbox"/> Burglar Alarm <input type="checkbox"/> Motion Detection <input type="checkbox"/> Fire Extinguishers <input type="checkbox"/> Security Guard/Service <input type="checkbox"/> Sprinklers (____%) <input type="checkbox"/> Cameras <input type="checkbox"/> Full Intrusion Perimeter Alarm			
Own/Lease:	Building Info:	Year:	Updated/Inspected	Additional Occupancies	
<input type="checkbox"/> Own	Number of Stories: _____	Roof: _____ / _____		_____	
<input type="checkbox"/> Lease	Building Sq. Ft.: _____	Plumbing: _____ / _____		_____	
	Sq. Ft. You Occupy: _____	Wiring: _____ / _____		_____	
	Year Built: _____	HVAC: _____ / _____		_____	
Loc . No.:		Address:			
Building Limit: \$		Personal Prop. Limit: \$		Occupancy Type:	
Construction Type: <input type="checkbox"/> Type 1-Frame <input type="checkbox"/> Type 2-Joisted Masonry <input type="checkbox"/> Type 3-Non-combustible <input type="checkbox"/> Type 4-Masonry non-combustible <input type="checkbox"/> Type 5-Modified fire resistive <input type="checkbox"/> Type 6-Fire resistive		Building Protection: (Check all that apply) <input type="checkbox"/> Local Alarm <input type="checkbox"/> Heat Detection <input type="checkbox"/> Other: _____ <input type="checkbox"/> Central Station Alarm <input type="checkbox"/> Smoke Detection <input type="checkbox"/> Burglar Alarm <input type="checkbox"/> Motion Detection <input type="checkbox"/> Fire Extinguishers <input type="checkbox"/> Security Guard/Service <input type="checkbox"/> Sprinklers (____%) <input type="checkbox"/> Cameras <input type="checkbox"/> Full Intrusion Perimeter Alarm			
Own/Lease:	Building Info:	Year:	Updated/Inspected	Additional Occupancies	
<input type="checkbox"/> Own	Number of Stories: _____	Roof: _____ / _____		_____	
<input type="checkbox"/> Lease	Building Sq. Ft.: _____	Plumbing: _____ / _____		_____	
	Sq. Ft. You Occupy: _____	Wiring: _____ / _____		_____	
	Year Built: _____	HVAC: _____ / _____		_____	

Property and Location Information (Continued)

Type 1-Frame - Buildings where the exterior walls are wood or other combustible materials including construction where combustible materials are combined with other materials such as brick veneer, stone veneer, wood iron-clad, stucco on wood.

Type 2-Joisted Masonry - Buildings where the exterior walls are constructed of masonry materials such as adobe, brick, concrete, gypsum block, hollow concrete block, stone, tile or similar materials and where the floors and roof are combustible.

Type 3-Non-Combustible - Buildings where the exterior walls and the floors and roof are constructed of, and supported by metal, asbestos, gypsum or other non-combustible materials.

Type 4-Masonry Non-Combustible - Buildings where the exterior walls are constructed of masonry materials as described in Code 2, with the floors and roof of metal or other non-combustible materials.

Type 5-Modified Fire Resistive - Buildings where the exterior walls and the floors and roof are constructed of masonry or fire resistive material with a fire resistance rating of one hour or more but less than two hours.

Type 6-Fire Resistive - Buildings where the exterior walls and the floors and roof are constructed of masonry or fire resistive materials having a fire resistance rating of not less than two hours.

For additional locations please complete and attach a separate Property Supplement.

Please indicate if Blanket Coverage is desired

Indicate the desired property deductible: \$500 \$1000 \$2500 \$5000 Other _____

Indicate the Coinsurance % desired 80% 90% 100% Other _____

Please list names and addresses of any mortgagees or loss payees for each location:

Loc. No.	Type	Name and Address
	<input type="checkbox"/> MTG <input type="checkbox"/> LP	
	<input type="checkbox"/> MTG <input type="checkbox"/> LP	
	<input type="checkbox"/> MTG <input type="checkbox"/> LP	
	<input type="checkbox"/> MTG <input type="checkbox"/> LP	
	<input type="checkbox"/> MTG <input type="checkbox"/> LP	

CGI Limits of Insurance

Current Carrier: _____ Current Premium: \$ _____

Each Occurrence/General Aggregate \$500,000/\$500,000 \$500,000/\$1 million
 \$1 million/\$1 million \$1 million/\$2 million \$1 million/\$3 million

Medical Expense \$5,000 \$10,000 Other: _____

Damage To Rented Premises \$100,000 Other _____

A separate liability limit will apply to Professional Services. The limit will follow the General Liability Limit shown above.

Additional Insureds

List any entities that need Certificates of Insurance or Additional Insured endorsements for liability coverage.

For Additional Insureds, describe their interest in your business.

Loc. No.	Name	Address
Describe Interest		
Describe Interest		
Describe Interest		

Medical Equipment Services & Receipts

Total receipts for the previous 12 months \$ _____

Total estimated receipts for the next 12 months \$ _____

Percent (%) of above receipts for the following services:	HOME USE	HOSPITAL USE	RECEIPTS NON-DISPOSABLE ITEMS	RECEIPTS DISPOSABLE ITEMS
Rental Receipts	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	%	
Sales-Retail	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	%	%
Sales-Distributor/Wholesale	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	%	%
Sales- Pharmaceutical	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	%	%
Sales-Medical Gases (high pressure or liquefied)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	 	%
Equipment Repair Receipts (other than equipment sold or rented by you)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parts %	Labor %
Other (describe):	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	%	%

Product Information

Description	Do you carry this item?	Average # In Stock	Do you repair this item?
Apnea Monitors	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Arterial Pressure Monitors (Invasive)	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Arterial Pressure Monitors (Non-Invasive – i.e. Blood Pressure Cuffs)	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Anesthesia Equipment	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Beds, Walkers, Crutches	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
CPMs	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Gas Analyzing Equipment	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Cardiac Out-put Machine	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Defibrillators	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Intensive Care Incubators	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Laser Equipment	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Life Function Monitoring	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Pacemakers	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
IPPB Machines	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Resuscitators	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Small Volume Nebulizers	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Transcutaneous Nerve Stimulators (tens units)	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
X-Ray Equipment	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No

Infusion Therapy Equipment	Do you carry this item?	Average # In Stock	Do you repair this item?
Enteral	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Parenteral	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Antibiotic Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Antibiotics for above	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Foods for above	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Disposal Tubing	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No

Oxygen Equipment	Do you carry this item?	Average # In Stock	Do you repair this item?
Oxygen Cylinders	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Oxygen Analyzers	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, are these used only to check your own Oxygen concentrators?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Oxygen Concentrators	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Oxygen Control Valves and Regulators	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No

Product Information (Continued)

Wheel Chairs / Scooters	Do you carry this item?	Average # In Stock	Do you repair this item?	# Rented Per Year	Percentage of Total Receipts
Wheel Chairs / Scooters	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		
What Repairs are performed?					

Vehicle Hand Controls	Do you carry this item?	Average # In Stock	Do you repair this item?	Percentage of Total Receipts	Do you install This item?
Vehicle Hand Controls	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No

Ventilators – Life Support	Do you carry this item?	Average # In Stock	Do you repair this item?	# Rented Per Year	Percentage of Total Receipts
Ventilators	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you hook patients up to the ventilator equipment?					<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you instruct on the use of ventilators?					<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, is a respiratory therapist responsible for the instruction?					<input type="checkbox"/> Yes <input type="checkbox"/> No

Medical Gas Piping Systems	Do you carry this item?	Average # In Stock	Do you repair this item?	Percentage of Total Receipts	# installed per year
Medical Gas Piping Systems	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		

Lifts	Do you carry this item?	Average # In Stock	Do you repair this item?	Percentage of Total Receipts	# installed per year
Stair Lift	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Ceiling Lift	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Vehicle Lift	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Type of lift:	<input type="checkbox"/> Hitch <input type="checkbox"/> Trunk <input type="checkbox"/> Van Conversion				
Vertical Lift	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		
Type of lift	<input type="checkbox"/> Elevator <input type="checkbox"/> Porch				

Grab Bars	Do you carry this item?	Average # In Stock	Do you repair this item?	Percentage of Total Receipts	# installed per year
Grab Bars	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		
How do you attach the Grab Bars to the structure?					

Do you carry any other equipment not listed above? Yes No

If Yes, please provide types and numbers of each: _____

Does the insured use Independent Contractors? Yes No

If yes, are certificates of insurance obtained/maintained from all Independent Contractors? Yes No

Does the insured require Independent Contractors carry insurance limits equal to or exceeding the insured's limits? Yes No

Please describe the work performed by Independent Contractors:

Business Operations Information

Is your facility accredited by: JCAHO CHAP ACHC Other: _____

Do you import directly from any foreign manufacturers? Yes No

If yes, please provide certificates of insurance evidencing foreign manufacturer's products liability insurance.

In U.S. dollars, what is the limit of their products liability insurance? \$ _____

Do you obtain certificates of insurance for products liability insurance from U.S. manufacturers of your products? Yes No

If yes, please provide copies of certificates.

If No, it is essential that you make every attempt to.

Are you a "Vendor" on the Products Liability Insurance carried by the U.S. manufacturers of your products? Yes No

If yes, please provide copies of certificates.

If No, it is essential that you make every attempt to.

Do you use a Rental Agreement when you provide equipment for your customers? Yes No

If yes, please attach a copy for review.

Do you use facilities other than manufacturers' authorized repair facilities for service or repair of equipment? Yes No

If yes, does the facility carry products/completed operations insurance coverage? Yes No

Are you an authorized repair facility for any manufacturer? Yes No

If yes, for what equipment? _____

Do any of the modifications that you make to equipment void any manufacturers' warranties? Yes No

If yes, please explain: _____

Are any products of others sold, repackaged or assembled under your label? Yes No

If yes, please explain: _____

Has any court, governmental agency, association or ethic committee ever reprimanded or disciplined you? Yes No

If yes, please explain: _____

Compressed Medical Gases

N/A

Do you provide compressed medical gases to your customers? Yes No

If yes, what gases? _____

Are you registered with the Federal Food and Drug Administration? Yes No

Have you ever been cited or fined for non-compliance with the

Federal Food and Drug Administration Compressed Medical Gases Guidelines? Yes No

If yes, please describe: _____

Are your oxygen cylinders pre-filled, or are they filled by you on the premises? Pre-Filled Filled

How many oxygen cylinders are on premises at any one time? _____

Please list location(s) where oxygen cylinders are stored: _____

When setting up oxygen-related equipment do you:

Check all equipment to insure proper working order prior to delivery? Yes No

Instruct the patient and/or caregiver as to the safe handling of the units? Yes No

Post "oxygen in use" signs in conspicuous places and warn patients and/or caregiver of the fire hazard? Yes No

Compressed Medical Gases (Continued)

- Have a check-off sheet indicating the information that was reviewed with the patient and/or caregiver? Yes No
- Perform repairs and calibrations per manufacturers' recommendations and at manufacturers' specified intervals? Yes No
- Have a follow-up program to check the equipment in the field at regular intervals? Yes No
- Explain any "no" answers: _____
- _____
- _____

Pharmaceuticals

N/A

- Do you operate a Closed- or Open-Door Pharmacy? Open Closed
- Do you have licensed pharmacists on staff? Yes No
- If yes, do they carry their own Professional Liability coverage? Yes No
- If yes, please provide a copy of each pharmacist's professional liability declarations page.
- Do you sell any over the counter drugs? Yes No
- Are prescriptions filled only for use with respiratory and infusion therapy equipment? Yes No

Professional Employee Information

N/A

- Do you use licensed or certified professionals? Yes No

If yes, please complete the following chart by showing the total number of people for each category that you use in your business:

Professional	How Many	Describe Function
Doctor		
Nurse		
Pharmacist		
Orthotist		
Prosthetist		
Other: _____		

- Do you currently offer any nursing service or have plans to do so in the future? Yes No

If yes, please explain: _____

Professional Liability

Current Professional Liability Carrier: _____

Current Limits of Liability: \$ _____ Each Incident
\$ _____ Aggregate

Current Premium: \$ _____
Current Deductible: \$ _____

Desired coverage: **Professional Liability Deductible Options are not available.**

- Limits of Liability: \$ 300,000 Each Incident/\$ 600,000 Aggregate
 \$ 500,000 Each Incident/\$1,000,000 Aggregate
 \$1,000,000 Each Incident/\$2,000,000 Aggregate
 \$1,000,000 Each Incident/\$3,000,000 Aggregate

Employee Benefits Liability

N/A

Note: This coverage is optional. Complete this section only if coverage is applicable.

Current EBL Carrier: _____ Current Premium: \$ _____

Current EBL Limits of Liability: Occurrence Claims-made Retroactive Date: _____
\$ _____ Each Incident / \$ _____ Aggregate

Desired EBL Limits of Liability: Occurrence Claims-made Retroactive Date: _____
 \$500,000/\$500,000 \$500,000/\$1 million \$1 million/\$2 million other: \$ _____

Does the company have an Employee Benefits handbook? Yes No

Has any claim been made, or suit filed against the company and/or its employees in the past five years alleging an error or omission in the administration* of your benefit programs? Yes No

If yes, please describe: _____

Does the company have knowledge of any matter(s) involving employee benefits, benefits administration, the handling of benefit claims, or any other benefits-related matter which would cause a reasonable person to believe that a claim or suit might result? Yes No

If yes, please describe: _____

* Determining who is eligible to participate; enrolling new participants; terminating participants; determining benefits; processing claims; collecting funds and applying them as required; preparing reports required by government agencies; giving advice to participants or prospective participants; providing reports, booklets, pamphlets, memos, or messages to participants.

Employment Practices Liability Insurance

N/A

Current Employment Practices Liability Carrier: _____ Occurrence Claims-Made Retroactive Date: _____

Current Limits of Liability: \$ _____ Each Incident Current Premium: \$ _____
\$ _____ Aggregate Current Deductible: \$ _____

Desired coverage: **Employment Practices Liability Deductible Options are not available.**

Limits of Liability: \$100,000 \$500,000 \$1,000,000 \$ _____

Note: Occurrence coverage not available.

Does the Company have a written Employment Practices handbook? Yes No

Has any claim been made or suit filed against the company and/or its employees in the past five years alleging a wrongful act, error or omission* in an employment-related matter? Yes No

If yes, please describe: _____

Does the company have knowledge of any matter(s) involving employment discrimination, wrongful termination, sexual harassment, or any other employment-related matter which would cause a reasonable person to believe that a claim or suit might result?

Yes No

If yes, please describe: _____

* Discrimination, coercion, harassment, or humiliation based on race, ethnic or national origin, marital status, medical condition, gender, age, physical appearance, physical or mental impairment, sexual orientation, or political affiliation; sexual harassment; termination of employment including retaliatory or constructive discharge; breach of employment contract; failure to employ; deprivation of a career opportunity; failure to promote; disciplinary action; demotion or evaluation; infliction of emotional distress.

Sexual or Physical Abuse Liability Insurance

N/A

Current Sexual or Physical Liability Carrier: _____ Occurrence Claims-Made Retroactive Date: _____

Current Limits of Liability: \$ _____ Each Incident Current Premium: \$ _____
\$ _____ Aggregate Current Deductible: \$ _____

Type of Coverage (i.e. Occurrence or Claims Made) for Sexual or Physical Abuse Liability Insurance will follow the Type of Coverage requested for General Liability.

Limits of Liability: \$250,000/\$500,000 \$1,000,000/\$1,000,000 \$1,000,000/\$2,000,000 \$1,000,000/\$3,000,000

Does the company have a written policy addressing abusive acts? Yes No

Are the employees required to sign an acknowledgement of receipt and understanding of the abusive act policy? Yes No

Has any claim been made, or suit filed against the company and/or its employees in the past five years alleging a sexual or physical abuse related matter? Yes No

If yes, please describe: _____

Does the company have knowledge of any matter(s) involving a sexual or physical abuse related matter which would cause a reasonable person to believe that a claim or suit might result? Yes No

If yes, please describe: _____

Crime

N/A

Current Carrier: _____ Current Premium: \$ _____

Fidelity

Commercial Blanket Limit of Insurance \$ _____

Number of Class I Employees/Volunteers (direct contact with funds) _____

Number of Class II Employees/Volunteers (all others) _____

Position Schedule Position Limit of Insurance

_____ \$ _____

_____ \$ _____

_____ \$ _____

_____ \$ _____

Forgery or Alterations \$ _____

MONEY AND SECURITIES

Note: \$2,500 money and securities coverage is provided under the Property Coverage Extensions.

If this limit is insufficient, please indicate the desired amount of additional insurance: \$ _____

GENERAL CRIME INFORMATION

List all persons managing funds: Name _____ Title _____

Name _____ Title _____

Name _____ Title _____

Crime (Continued)

Do the persons managing funds turn over this function to another for a period of 2 weeks, every year to prevent theft? Yes No

Are Invoices or Requisitions kept? (This documents what item or service is being paid for, who the vendor is, and who authorized the item or service). Yes No

Are Invoices or Requisitions, Check Register and Bank Statement cross-checked against each other? Yes No

Largest amount of petty cash kept on hand? \$ _____

Is money ever stored in the building overnight? Yes No

If yes, amount and how stored: _____

All receipts are deposited in a bank within: 2 days 1 week Over 1 week

Are all incoming checks immediately stamped "For Deposit Only"? Yes No

Do all outgoing checks require 2 signatures? Yes No

If No, do checks over a certain amount require 2 signatures? Yes No

If Yes, please indicate amount \$ _____

By whom and how often are the accounts examined? _____

When were the accounts last examined? _____

What is your annual revenue? \$ _____

Automobile Liability

N/A

Current Automobile Liability Carrier: _____ Current Premium: \$ _____

Current Limit of Liability : \$ _____

Indicate Desired Limits Below:

\$ _____ Auto Liability Hired & Non-Owned Auto Liability Only (Please complete section below)

\$ _____ Medical Payments

\$ _____ PIP / No-Fault (Medical Expense Benefits – Applies Only in PA)

\$ _____ Additional PIP (Increased Medical Expense Benefits – Applies Only in PA)

\$ _____ Uninsured Motorists/ Underinsured Motorists B.I. Stacking Non-Stacking (if applicable)

\$ _____ Uninsured Motorists/ Underinsured Motorists P.D.

Does the organization service any major metropolitan areas? Yes No

If yes, please describe: _____

What is the radius of your operations? _____ Miles

Does the company allow owners/employees to take company owned vehicles home or on personal business? Yes No

If yes, please describe: _____

Does the organization own or lease any vehicles that are not shown on the Vehicle Schedule of this survey? Yes No

If yes, please describe: _____

Physical Damage Coverage

Please indicate the desired deductible for vehicles:

Comprehensive (ACV) \$500 \$1000 \$2000 \$3000 Other \$ _____

Collision (ACV) \$500 \$1000 \$2000 \$3000 Other \$ _____

Vehicle Schedule						
Veh	Year	Make, Model, Body Type	Cost New	VIN (Required)	GVW	Loc. #
1.			\$			
2.			\$			
3.			\$			
4.			\$			
5.			\$			
6.			\$			
7.			\$			
8.			\$			

*If more than 10 vehicles, please attach Auto Acord Schedule.

*Cost New is required if Physical Damage Coverage is requested.

*Gross Vehicle Weight (GVW) is required

Additional Insured / Loss Payee

Do any of these vehicles require an Additional Insured or Loss Payee to be listed on the policy? Yes No

If yes, indicate the vehicle number and the name and address of the Additional Insured or Loss Payee:

Veh. #	Type	Name and Address
	<input type="checkbox"/> A.I. <input type="checkbox"/> LP	
	<input type="checkbox"/> A.I. <input type="checkbox"/> LP	
	<input type="checkbox"/> A.I. <input type="checkbox"/> LP	
	<input type="checkbox"/> A.I. <input type="checkbox"/> LP	
	<input type="checkbox"/> A.I. <input type="checkbox"/> LP	

Hired / Non-Owned Coverage

Hired / Borrowed Liability: State(s): _____ Cost of Hire: \$ _____ If Any Basis

Non-Owned Liability: State(s): _____

Group Type: Employees / Number _____ Partners / Number _____

Hired Physical Damage: State(s): _____ # of Days: _____ # of Vehicles: _____

Coverage: Comprehensive Deductible: \$ _____

Collision Deductible: \$ _____

Do you or any of your employees use their own vehicles for company business? Yes No

If yes, please indicate for what purpose:

Delivery of Products Sales Other, please describe: _____

Driver Information

Does the organization check MVR's? Yes - all employees Yes - drivers only No

If yes, how often? _____

Does the company have written criteria for acceptable MVR's? Yes No

Do all drivers have a license commensurate with state or local law (CDL, etc.)? Yes No

Please describe the driver training program currently being used: _____

Does a file exist for each driver containing documentation for all of the above information? Yes No

What selection criteria are used to select new drivers? _____

Number of drivers currently employed: _____ Full time _____ Part time _____ Contract

Percent of driver turnover in the last twelve months: _____

Vehicle Maintenance

Vehicle maintenance procedures:

Are daily vehicle inspection reports completed? Yes No

Are periodic maintenance checks done by a mechanic? Yes No

Are vehicle maintenance records kept? Yes No

Does the company employ its own mechanics? Yes No

Does the company store or service the vehicles of others? Yes No

Excess Liability

Limit of Insurance (choose) \$1 Million \$2 Million \$3 Million \$4 Million \$5 Million

Please indicate the following underlying coverage information for Auto and Employers Liability. If this information is not provided, Excess Employers Liability and Auto Liability coverage will not be included under any policy that is dependent upon the information contained in this survey.

Note: These limits will apply to Auto Liability and Employers Liability. The minimum required underlying limits are:

Auto Liability— \$1 million per occurrence.

Employers Liability— \$500,000 bodily injury by accident/\$500,000 bodily injury by disease/\$500,000 annual aggregate.

Employers Liability Insurer*: _____

Policy Number: _____ Policy Period: _____

Employers Liability (Coverage B) Limits: \$ _____ Bodily Injury by Accident

\$ _____ Bodily Injury by Disease

\$ _____ Annual Aggregate

To provide coverage excess over another auto carrier, **you must provide us with a copy of your declarations page** from your current policy.

Auto Liability Insurer*: _____

**Excess Employers Liability and Auto Liability are subject to approval of the insurer providing the underlying coverage.*

Prior Loss Information for CGL, Professional Liability, & Property

Date of Occurrence	Date of Claim	Type of Claim & Description of Occurrence	Amount Paid	Amount Reserved	Claim Status
					<input type="checkbox"/> Open <input type="checkbox"/> Closed
					<input type="checkbox"/> Open <input type="checkbox"/> Closed
					<input type="checkbox"/> Open <input type="checkbox"/> Closed
					<input type="checkbox"/> Open <input type="checkbox"/> Closed

Attachments

Attachments to this application must include the following:

- Three years of currently valued, within 60 days, hard copy loss runs, including loss details and descriptions (for all lines requested).
- Copy of declarations pages to verify claims made or occurrence coverage (General Liability, Professional Liability, Employment Practices Liability, Employee Benefits Liability).
- A complete driver list with drivers' names, license numbers, dates of birth, and date of hire. – if applicable.
- Rental Agreement used when Supplying Customers with Equipment. – if applicable.
- Certificates of Insurance from Manufacturers naming the Insured as an Additional Insured – Vendor. – if applicable.

APPLICATION SIGNATURES & STATE FRAUD STATEMENTS

NOTICE TO FLORIDA APPLICANTS: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony in the third degree.

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 THEIR KNOWLEDGE AND BELIEF.

Applicant's Signature: _____ Date: _____

Name and title (please print): _____

Insurance Broker's Signature: _____ Date: _____

(To be signed by someone who does not have access to funds)