HOMed BY McNeil&Co.

HOME MEDICAL EQUIPMENT DEALER INSURANCE SURVEY

P.O. Box 5670
Cortland, NY 13045
Phone: (800) 822-3747
Fax: (607) 756-5051
Email: applications@mcneilandcompany.com

General Information

Date of survey: _____ Insurance Renewal Date: _____ Date Proposal Needed: _____

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: _____

Telephone: _____ Fax: _____ 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: ☐ Type 1-Frame ☐ Type 2-Joisted Masonry ☐ Type 3-Non-combustible ☐ Type 4-Masonry non-combustible ☐ Type 5-Modified fire resistive ☐ Type 6-Fire resistive	**Building Protection: (Check all that apply)** ☐ Local Alarm ☐ Central Station Alarm ☐ Burglar Alarm ☐ Fire Extinguishers ☐ Sprinklers (_____%)	☐ Heat Detection ☐ Smoke Detection ☐ Motion Detection ☐ Security Guard/Service ☐ Cameras ☐ Full Intrusion Perimeter Alarm ☐ Other: ______________

Own/Lease:	**Building Info:**	**Year: Updated/Inspected**	**Additional Occupancies**
☐ Own	Number of Stories: ______	Roof: ________/________	______________________
☐ 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: ☐ Type 1-Frame ☐ Type 2-Joisted Masonry ☐ Type 3-Non-combustible ☐ Type 4-Masonry non-combustible ☐ Type 5-Modified fire resistive ☐ Type 6-Fire resistive	**Building Protection: (Check all that apply)** ☐ Local Alarm ☐ Central Station Alarm ☐ Burglar Alarm ☐ Fire Extinguishers ☐ Sprinklers (_____%)	☐ Heat Detection ☐ Smoke Detection ☐ Motion Detection ☐ Security Guard/Service ☐ Cameras ☐ Full Intrusion Perimeter Alarm ☐ Other: ______________

Own/Lease:	**Building Info:**	**Year: Updated/Inspected**	**Additional Occupancies**
☐ Own	Number of Stories: ______	Roof: ________/________	______________________
☐ 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: ☐ Type 1-Frame ☐ Type 2-Joisted Masonry ☐ Type 3-Non-combustible ☐ Type 4-Masonry non-combustible ☐ Type 5-Modified fire resistive ☐ Type 6-Fire resistive	**Building Protection: (Check all that apply)** ☐ Local Alarm ☐ Central Station Alarm ☐ Burglar Alarm ☐ Fire Extinguishers ☐ Sprinklers (_____%)	☐ Heat Detection ☐ Smoke Detection ☐ Motion Detection ☐ Security Guard/Service ☐ Cameras ☐ Full Intrusion Perimeter Alarm ☐ Other: ______________

Own/Lease:	**Building Info:**	**Year: Updated/Inspected**	**Additional Occupancies**
☐ Own	Number of Stories: ______	Roof: ________/________	______________________
☐ Lease	Building Sq. Ft.: ______	Plumbing: ________/________	______________________
	Sq. Ft. You Occupy: ______	Wiring: ________/________	______________________
	Year Built: ______	HVAC: ________/________	______________________

Property and Location Information

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. #	Type	Name and Address
	☐ MTG ☐ LP	
	☐ MTG ☐ LP	
	☐ MTG ☐ LP	
	☐ MTG ☐ LP	
	☐ MTG ☐ LP	

CGL 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	☐ Yes ☐ No	☐ Yes ☐ No	%	
Sales-Retail	☐ Yes ☐ No	☐ Yes ☐ No	%	%
Sales-Distributor/Wholesale	☐ Yes ☐ No	☐ Yes ☐ No	%	%
Sales- Pharmaceutical	☐ Yes ☐ No	☐ Yes ☐ No	%	%
Sales-Medical Gases (high pressure or liquefied)	☐ Yes ☐ No	☐ Yes ☐ No		%
Equipment Repair Receipts (other than equipment sold or rented by you)	☐ Yes ☐ No	☐ Yes ☐ No	Parts %	Labor %
Other (describe):	☐ Yes ☐ No	☐ Yes ☐ No	%	%

Product Information

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

Product Information (Continued)

Infusion Therapy Equipment	Do you carry this item?	Average # In Stock	Do you repair this item?
Enteral	☐ Yes ☐ No		☐ Yes ☐ No
Parenteral	☐ Yes ☐ No		☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No		☐ Yes ☐ No
Antibiotic Therapy	☐ Yes ☐ No		☐ Yes ☐ No
Antibiotics for above	☐ Yes ☐ No		☐ Yes ☐ No
Foods for above	☐ Yes ☐ No		☐ Yes ☐ No
Disposal Tubing	☐ Yes ☐ No		☐ Yes ☐ No

Oxygen Equipment	Do you carry this item?	Average # In Stock	Do you repair this item?
Oxygen Cylinders	☐ Yes ☐ No		☐ Yes ☐ No
Oxygen Analyzers	☐ Yes ☐ No		☐ Yes ☐ No
If Yes, are these used only to check your own Oxygen concentrators?	☐ Yes ☐ No		
Oxygen Concentrators	☐ Yes ☐ No		☐ Yes ☐ No
Oxygen Control Valves and Regulators	☐ Yes ☐ No		☐ Yes ☐ No

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	☐ Yes ☐ No		☐ Yes ☐ 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	☐ Yes ☐ No		☐ Yes ☐ No		☐ Yes ☐ 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	☐ Yes ☐ No		☐ Yes ☐ No		
Do you hook patients up to the ventilator equipment?					☐ Yes ☐ No
Do you instruct on the use of ventilators?					☐ Yes ☐ No
If yes, is a respiratory therapist responsible for the instruction?					☐ Yes ☐ 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	☐ Yes ☐ No		☐ Yes ☐ No		

Lifts	Do you carry this item?	Average # In Stock	Do you repair this item?	Percentage of Total Receipts	# installed per year
Stair Lift	☐ Yes ☐ No		☐ Yes ☐ No		
Ceiling Lift	☐ Yes ☐ No		☐ Yes ☐ No		
Vehicle Lift	☐ Yes ☐ No		☐ Yes ☐ No		
Type of lift:	☐ Hitch ☐ Trunk	☐ Van Conversion			
Vertical Lift	☐ Yes ☐ No		☐ Yes ☐ No		
Type of lift	☐ Elevator	☐ Porch			

Product Information (Continued)

Grab Bars	Do you carry this item?	Average # In Stock	Do you repair this item?	Percentage of Total Receipts	# installed per year
Grab Bars	☐ Yes ☐ No		☐ Yes ☐ 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

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 Current Premium: $ _____

$_____ Aggregate 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: ☐ $100,000/$300,000 ☐ $500,000/$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 (maximum $50,000) $ _____

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 (maximum $25,000) $ _____

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 _____

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 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.			$			
9.			$			
10.			$			

*** If more than 10 vehicles, please attach Auto Acord Schedule.**
*** Cost New is required if Physical Damage Coverage is requested.**
*** Gross Vehicle Weight 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
	☐ A.I. ☐ LP	
	☐ A.I. ☐ LP	
	☐ A.I. ☐ LP	
	☐ A.I. ☐ LP	
	☐ A.I. ☐ 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 - $1,000,000 bodily injury by accident / $1,000,000 bodily injury by disease / $1,000,000 annual aggregate.

Employers Liability Insurer*: _____

Policy Number: _____ Policy Period: _____

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

$ _____ Bodily Injury by Disease – Each Employee

$ _____ Bodily Injury by Disease – Policy Limit

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

Prior Loss Information

Date of Occurrence	Date of Claim	Type of Claim & Description of Occurrence	Amount Paid	Amount Reserved	Claim Status
					☐ Open ☐ Closed
					☐ Open ☐ Closed
					☐ Open ☐ Closed
					☐ Open ☐ 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.**