

# Benchmark

## MANAGEMENT GROUP, INC.

1730 Park Street, Suite 214 Naperville, IL 60563  
 Phone: (630) 778-7000 Fax: (630) 778-7007

### MEDICAL EQUIPMENT SUPPLY STORES APPLICATION

Applicant's Name \_\_\_\_\_  
 Mailing Address \_\_\_\_\_  
 \_\_\_\_\_  
 Location \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 (Please complete a separate application for each location.)

Agent Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**PROPOSED EFFECTIVE DATE:**  
 From \_\_\_\_\_ To \_\_\_\_\_

12:01 A.M., Standard Time at the mailing address of the Applicant.

**Applicant is:**     Individual     Corporation     Partnership     Joint Venture  
                           Limited Liability Company     Other (Specify): \_\_\_\_\_

**LIMITS OF LIABILITY REQUESTED**

**PREMIUMS**

General Aggregate	\$	Premises/Operations
Products & Completed Operations Aggregate	\$	\$
Personal & Advertising Injury	\$	Products/Completed Operations
Each Occurrence	\$	\$
Fire Damage (any one fire)	\$	Other
Medical Expense (any one person)	\$ Excluded	\$
Professional Limit	\$	Professional
Each Medical Incident	\$	\$
Aggregate	\$	
Other Coverages, Restrictions, and/or Endorsements		Total
Deductible	\$	\$

1. **Full Named Insured** (if not shown above): \_\_\_\_\_  
 \_\_\_\_\_

2. **Type of operation and annual sales:**  
 Sale of Medical, Hospital and Surgical supplies \$ \_\_\_\_\_  
 Rental/leasing of home care products/equipment to consumers \$ \_\_\_\_\_  
 Pharmacy \$ \_\_\_\_\_  
 Other – Describe: \_\_\_\_\_  
 \_\_\_\_\_

3. Are Patrons fitted with rehabilitative items prescribed by doctors, such as back braces or neck collars?     Yes     No  
 If Yes, Is the person doing the fitting an accredited surgical appliance technician?     Yes     No.

4. Percentage of equipment sold or leased/rented which is physician prescribed: \_\_\_\_\_%

5. Percentage of operations from sale of non-medical products, such as office furniture, printed materials (labels, charts, prescription forms), scales, etc.? \_\_\_\_\_%

6. Sale or rental of oxygen and respiratory equipment, such as oxygen concentrators, cylinders and aspirators?  
 Yes  No. If Yes, percentage of total operation: \_\_\_\_\_%
7. Do you deal in the sale or rental of any other gases?  Yes  No. If Yes, describe: \_\_\_\_\_  
 \_\_\_\_\_  
 Do you do any refilling of oxygen (or other gases)?  Yes  No
8. Do you buy or sell used equipment?  Yes  No. Percentage of total operation \_\_\_\_\_%  
 If Yes, do you recondition/repair, prior to resale?  Yes  No  
 Do you sell "as is"?  Yes  No
9. Do you subcontract repair or installation operations?  Yes  No. If Yes, do you obtain Hold Harmless Agreements from your subcontractors?  Yes  No.
10. Is equipment maintenance performed and documented according to manufacturers guidelines?  Yes  No.
11. Are customers given any applicable Material Data Safety Sheets prepared by the equipment manufacturer?  
 Yes  No
12. What are your procedures for reporting any malfunctioning devices to the Federal Drug Administration?  
 \_\_\_\_\_  
 \_\_\_\_\_
13. Sale, rental or leasing of any of the following equipment or machines? Indicate by "x".  
 \_\_\_Anesthesia apparatus    \_\_\_Inhalation therapy machines    \_\_\_Cardiac Defibrillators  
 \_\_\_X-ray, fluoroscopy    \_\_\_Resuscitation equipment    \_\_\_Radiation therapy  
 \_\_\_Kidney machines    \_\_\_Audiometers    \_\_\_EKG machines  
 \_\_\_Diathermy machines    \_\_\_Suction or Irrigation apparatus    \_\_\_Ventilators  
 \_\_\_Oscilloscopes    \_\_\_Metal & foreign body locators    \_\_\_Heart Monitoring
14. Do you manufacture or directly import any medical/ surgical equipment?  Yes  No  
 If Yes, provide details: \_\_\_\_\_  
 \_\_\_\_\_
15. Do you employ or subcontract the services of any Respiratory Therapist or Physician?  Yes  No
16. Are you a member of any Health Industry Association?  Yes  No. If Yes, which?  
 (HIDA, JCAHCO, IMDA, other) \_\_\_\_\_  
 \_\_\_\_\_
17. If a member of the Joint Commission on the Accreditation of Health Care Organizations, are you Certified?  
 Yes  No. If Yes, attach copy of latest certification.

**Any other premises or operations exposures not stated in this application?**  Yes  No. If Yes, attach a complete description and underwriting/rating information.

SCHEDULE OF HAZARDS								
Loc. No.	Classification	Class Code	Premium Bases: (s) Gross Sales (p) Payroll (a) Area (c) Total Cost (t) Other	Terr.	Rate		Premium	
					Prem/Ops	Products Comp Ops	Prem/Ops	Products Comp Ops

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During the past five years, have any claims been made or suit brought against you because of alleged malpractice, error, mistake or premises accident in any manner out of applicant's operation?  Yes  No

If Yes, date: \_\_\_\_\_ Please explain: \_\_\_\_\_

During the past three years, has any company cancelled, declined, or refused similar insurance to the applicant? (Not applicable in Missouri.)  Yes  No. If Yes, explain: \_\_\_\_\_

Previous Insurer: Indicate premium and losses for past three years. Describe all losses.

YEAR	COMPANY	POL. #	OCCURRENCE OR CLAIMS MADE	PREMIUM	LOSSES PAID	LOSSES RESERVED	DESCRIPTION

This application does not bind the applicant nor the Company to complete the insurance, but it is agreed that the information contained herein shall be the basis of the contract should a policy be issued.

**APPLICABLE IN THE STATE OF 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.

**FRAUD WARNING**

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.

NAME AND TITLE \_\_\_\_\_

APPLICANT'S SIGNATURE \_\_\_\_\_ Date \_\_\_\_\_

Name and Phone Number of individual to contact for inspection/audit \_\_\_\_\_

Agent Name \_\_\_\_\_ Agent License Number \_\_\_\_\_

**(Applicable to Florida Agents Only.)**

IMPORTANT NOTICE

As part of our underwriting procedure, a routine inquiry may be made to obtain applicable information concerning character, general reputation, personal characteristics and mode of living. Upon written request, additional information as to the nature and scope of the report, if one is made, will be provided