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POLARIS
Risk Management & Insurance Services

Account Information

Insured's Name: _____
Mailing Address: _____
City: _____ State: _____ Zip: _____ Phone: _____
Contact Name : _____ Fax: _____
Coastal State: Yes / No If yes, distance to body of water: _____ Number of Locations: _____
Do you have a WEBSITE? Yes / No If yes: _____
EMAIL ADDRESS: _____

Description of Operations

Corporation: Yes / No Type: _____ Individual: Yes / No
Provide a brief description of operations, including years in business: _____
_____
_____
If new venture, provide years experience: _____
Any business conducted other than DME or O&P: Yes / No If yes, please describe: _____
_____
Current Carrier: _____ Premium: _____ Yrs with Carrier: _____
Prior Insurance Carrier and Policy Date: _____
Practitioner for Patient Care Certified: Yes / No
Professional Liability ☐ Occurrence ☐ Claims Made ☐ Prior Acts Date _____
(Attach Copy of Prior Claims Made Policy Declarations if requesting Prior Acts.)
General Liability ☐ Occurrence ☐ Claims Made ☐ Prior Acts Date _____
(Attach Copy of Prior Claims Made Policy Declarations if requesting Prior Acts.)

General Information

Member of any of the following? : *(Please circle)* AOPA AAHomecare Pedorthic Footwear Assoc.
Other : _____
Is the Facility Accredited? : YES / NO
If yes, By Who and What Year? : _____

General Questions

Have you or anyone ever been convicted of fraud, arson or any other crimes related to a property loss in the last five years? YES / NO
How close is the nearest fire department? _____ Miles
Are there any fire hydrants with-in 200 feet of the building? YES / NO
Who has access to cash registers/safes? _____
Who has check writing authority? _____
Are pre-employment criminal background checks done? YES / NO Run MVR's? YES / NO
Do you make daily deposits? YES / NO Do you use an armed guard service? YES / NO
How many individuals work with accounts payable? _____
Do you require those working with accounts to take at least a weeks' vacation? YES / NO
Have you had any insurance losses or filed any claims in the past 3 years? YES / NO
If yes, please describe below:

Description of Loss	Date of Loss	Amount Paid

Please Indicate if you: Sell / Rent / Distribute / Repair Any of the Following Equipment

For Each Type, Please Check Box and Indicate Sales Amount

☐ Monitoring Equipment	$	☐ TENS Units	$
Type of Equipment:		☐ CPAP / BYPAP	$
1)		☐ Halos / Cranial Helmets	$
2)		☐ Buy / Sell / Repair	$
3)		Used Equipment	
☐ Diagnostic Equipment	$	1)	
1)		2)	
2)		3)	
☐ Life Sustaining Equip.	$	☐ Devices that are implanted	$
1)		☐ Vehicle Control Devices	$
2)		☐ Hoists	$
☐ Oxygen Support	$	☐ Wheelchairs/Cots/Gurneys	$
1)		☐ Lifts	$
2)		☐ Ramps	$
☐ Respiratory Support	$	☐ Grab Bars	$
☐ Respirators	$	Do you Install?	YES / NO
☐ Hand Controls	$	Years Experience Installing?	_____
☐ Other Auto Related Equip.	$	☐ Pharmaceuticals, Drugs	$
☐ Surgical Equipment	$	*(Please List on Separate Page)*	
☐ Installation of Stair Chairs	$	☐ Installation of Patient Lifts	$

If provider does installation of equipment, how many years of installation experience? _____

Please Indicate Estimated Sales for Each Category :	Last Year	Next Year
Practitioner Patient Care: Includes all items you make, fit, alter, adjust for patients.	$_____	$_____
Manufacturing: Items manufactured by and sold to others to distribute. No patient care for this class.	$_____	$_____
Wholesale Distribution: Includes all items purchased from others that you resell to other facilities.	$_____	$_____
Retail Customers (DME): Include items that you rent/sell to others over the counter that you do not repackage, change, or modify.	$_____	$_____
Medical Equipment: Repair or Installation of any type of Medical Equipment.	$_____	$_____

Please provide a specific description for any "Checked" responses from the previous page. If available, please provide brochures with submission. _____

_____

_____

Do you re-package or re-label any items? YES / NO If yes, please explain: _____

_____

Do you directly import any foreign products into the U.S.? YES / NO If yes, please list products _____

_____

Do you require all vendors, manufacturers, distributors and any independent contractor to:
Provide a Certificate of Insurance to show that the above carries and maintains coverage? YES / NO
(Please provide copies of these certificates, if applicable.)

Please Provide the Following Regarding Staff :

# of Full Time Employees: _____	Part Time: _____	Independent Cont: _____

Position	# Employed	Yrs. Employed	Ind. Cont.	Other
Practitioner				
Respiratory Therapist				
Nurse				
Technician				
Physical Therapist				

_____

_____

Property Description / Locations :

FULL Location Address	# of Stories	Construction / PC	Year Built	Sprinkler System	Sq. Feet
1)					
2)					
3)					
4)					
5)					

Note: If requesting building coverage and the building is over 30 years old, please provide information when the roof, plumbing, electrical & heating systems have been updated: _____

If a coastal state, please indicate locations' roof type: _____

Coverage :	Location #1	Location #2	Location #3	Location #4	Location #5
Building Value :					
Contents Value :					
Out Buildings (Garage, Sheds, etc.) :					

**Note: Values should be 100% Replacement Cost. Unless otherwise requested or noted, all deductibles are $500.

Facility Safety

Central Station Alarm System for : Fire, Smoke, Break-in YES / NO Monitored 24 hours a day? YES / NO

Are all stairs covered with anti-slip treads? : YES / NO

Are handrails provided on all stairways? : YES / NO Hallways? : YES / NO

Are parking lots free of debris and are surfaces smooth? : YES / NO

Exterior of building well lit? : YES / NO

Are the edges of curbs, sidewalks and steps color coded to identify raised surfaces? : YES / NO

Who is responsible for the maintenance of building, such as snow/ice removal? : _____

Please explain any "NO" responses : _____

_____

_____

Do you lease any part of the premises to another business or are there any other business activities, other than HME/DME, conducted on the premises that are not directly related to the coverage being requested on this application? If so, please explain _____

_____

_____

Additional Insured – Please list Names and Addresses Below and their Interest in your Operations.

Name & Address — Interest of Additional Insured

1) _____

2) _____

3) _____

Would you like a quote for :

Flood Insurance	YES / NO	Wind Insurance	YES / NO
Directors/Officers	YES / NO	Employment Practice Liab. Coverage	YES / NO

Would you like an Umbrella to go over existing policy? YES / NO

(Supplemental Application Required.) If yes, Limit desired $_____

If yes for Umbrella, please include the following:

Primary Auto Liab. Premium : _____ Carrier: _____

Work Comp Liab. Limits : _____ Carrier: _____

Number of Auto(s)	Private Pass.	Trucks	Vans

Fraud Statement

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any false information or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act which is a crime.

Date : _____ Applicants Signature : _____