JAMES RIVER INSURANCE	**James River Insurance Company and its Subsidiaries** 6641 West Broad Street, Suite 300 Richmond, VA 23230	**Allied Healthcare Durable Medical Equipment Application** **ALLIED HEALTHCARE Division** Email to AH@jamesriverins.com or, Fax to 804-420-1054

APPLICANT'S INSTRUCTIONS:

1. Answer all questions completely. Please attach extra sheets as required. Incomplete or illegible applications may be discarded.
2. Application must be signed and dated by the owner, partner, or officer not earlier than 45 days before the proposed effective date of coverage.
3. Please read the statements at the end of this application carefully. Thank you!

ALLIED HEALTHCARE DURABLE MEDICAL EQUIPMENT SUPPLEMENTAL APPLICATION

I. GENERAL INFORMATION:

Estimated receipts in the next 12 months: $ _____

Actual receipts in the last 12 months: $ _____

Any pharmaceutical product/solutions sales? ☐ Yes ☐ No

If Yes, what percentage of the above est. receipts will be pharmaceuticals? % _____

1. Non-expendable Items:
   (Excluding diagnostic or treatment equipment or devices. This category includes, but is not limited to hospital beds, bathroom safety bars, portable toilets patient lifts or hoists, traction apparatus, ambulatory aids such as walkers, strollers, canes, crutches, wheelchairs, prosthetic devices and IV stands, including medical and surgical instruments unless considered diagnostic or treatment.)

   Estimated receipts in the next 12 months: $ _____

   Actual receipts in the last 12 months: $ _____

   Any lease or rental of the above equipment? ☐ Yes ☐ No

   If Yes, lease/rental of equipment equals: _____% of the above estimated receipts.

Inventory (products sold or rented or services rendered) gross revenue must be broken into percentages and must equal 100%

	Sales	Rentals	%		Sales	Rentals	%	**Services**	Sales	Rentals	%
Apnea Monitor				Wheelchair Lifts				Sleep Study			
Ventilator				Stair Lifts				Pharmacy[1]			
Defibrillator				Ceiling Lifts				Repair & Service			
Parenteral Therapy				Grab/Safety Bar				Other (please list)			
Diabetic Shoes				Braces				**Permanent Installation*:**			
Liquid Oxygen				CPAP				Elevators			
Scooters/TriCarts				Nebulizers				Ramps			
Bed, Walkers, Crutches				ADLs				Ceiling Lifts			
CPMs				Tens Units				Stair			

Enteral Therapy

Lift Chairs

Oxygen Concentrator

Motorized Wheelchairs

Wheelchairs

Latex Gloves

LAL Mattress

Uniforms

Disposables

Diabetes Monitoring

Diabetes Testing

Other Prod Rent/Sell Please List:

Lifts

Wheelchair Lifts

Hand Controls in Autos

Wheelchair Lifts in Autos

Grab Bars

Other Permanent Install Please List:

2. Have any of the products that you distribute ever been recalled? If Yes, explain. ☐ Yes ☐ No
Please describe process for determining if any products you sell or lease have been recalled by the manufacturer and describe your recall process:

3. Is the applicant named as an Additional Insured-Vendor on the Manufacturer's policy for:
☐ All Products ☐ Some Products ☐ No Products
If for "Some" products, list those products and the Annual Receipts for each:

4. Are written instructions for the use of the products provided to the user? ☐ Yes ☐ No
If Yes, are the written instructions reviewed with and required to be signed off by the user? ☐ Yes ☐ No

5. Do you modify any products in any way after their original manufacture? ☐ Yes ☐ No
If Yes, please explain:

6. Do you repackage or re-label any items obtained from suppliers? ☐ Yes ☐ No
If Yes, please explain:

7. Is any equipment sold with the applicant's label? ☐ Yes ☐ No
If Yes, please explain:

8. Do you maintain a written quality control program? ☐ Yes ☐ No

9. Do you have your own sales staff? ☐ Yes ☐ No
If Yes, are they trained by the manufacturer? ☐ Yes ☐ No

10. Are all devices and/or equipment checked and their condition documented prior to their release? ☐ Yes ☐ No

11. Is preventive maintenance performed on all equipment & devices according to a written schedule? ☐ Yes ☐ No

12. Do you repair or sell other people's used equipment? ☐ Yes ☐ No
If Yes, please explain what type and estimated annual revenues:

13. Are serial numbers of the finished product shown on shipment invoices and complete records kept of inventory shipments? ☐ Yes ☐ No

14. Do you use the services of an EPA approved contractor to dispose hazardous waste materials? ☐ Yes ☐ No

15. Does applicant have any exposure to nuclear or radioactive materials? ☐ Yes ☐ No
If Yes, please explain:

16. For life sustaining equipment/monitoring devices describe maintenance and emergency protocols:

17. Do you distribute oxygen cylinders? ☐ Yes ☐ No
Are they pre-filled or do you fill them at your premises?

18. Do you follow DOT and FDA guidelines on safe practices for handling and provision of oxygen and related equipment? ☐ Yes ☐ No

II. MAINTENANCE AND/OR REPAIR OF EQUIPMENT – LEASED OR SOLD:

19. Do you subcontract labor or installation, service or repair of any products? ☐ Yes ☐ No

    If yes, describe what equipment this applies to: _____

    _____

    Please describe which types of equipment YOU perform maintenance or repairs on: _____

    _____

    Are manufacturer recommendations followed for all maintenance and repair of equipment and are all technicians manufacturer trained and certified? ☐ Yes ☐ No
    If No, please explain: _____

    _____

20. Are certificates of insurance obtained from those entities that provide the maintenance and services? ☐ Yes ☐ No

    What limits of liability do you require of these maintenance and/or repair subcontractors?

    _____

    _____

NOTICE TO APPLICANT: The coverage applied for is solely as stated in the policy. If policy is issued on a "CLAIMS MADE" or "CLAIMS MADE AND REPORTED" basis, it provides coverage only for those claims that are first made against the insured during the policy period unless the extended reporting period option is exercised in accordance with the terms of the policy. If issued on an "OCCURRENCE" basis, the policy provides coverage only for those occurrences that take place during the policy period.

The Insurer will rely upon this application and all such attachments in issuing the policy. If the information in this application or any attachment materially changes between the date this application is signed and the effective date of the policy, the Applicant will promptly notify the Insurer, who may modify or withdraw any outstanding quotation or agreement to bind coverage.

In 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.

In all other states: It is a crime for any person to knowingly provide or facilitate in providing any false, incomplete, or misleading information to an insurance company. Penalties may include fines, imprisonment and denial of insurance benefits.

WARRANTY: I warrant to the Insurer, that I understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy of insurance and deemed incorporated therein, should the Insurer evidence its acceptance of this application by issuance of a policy. I authorize the release of claim information from any prior insurer to James River Insurance Company and its Subsidiaries, 6641 West Broad Street, Richmond, VA 23230.

Applicant's Name:	Signature:
Title:	Date:

