



BYRNE - KIM & ASSOCIATES
Insurance Services, Inc.

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Telephone (949) 249-2540
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Home Medical Equipment Insurance Survey

General Information:

Date of Survey: _____ Insurance Renewal Date: _____

Legal Name of Organization: _____

FIEN#: _____

Mailing Address: _____

County: _____

Telephone: _____ Fax: _____

Contact Name: _____ Contact Title: _____

Website Address: _____ Email Address: _____

Business Information:

Description of Organization: Sole Proprietor Partnership Corporation Other: _____

Years in Business? _____ Is this a New Venture? _____ Years Experience? _____ Non-Profit? Y / N

Is your Business a Subsidiary or Division of another Company? Yes / No

If yes please provide the name of the Company, the address & relationship: _____

Has your Business had a change in ownership over the past 3 years? If so please provide details: _____

Has any Insurance Carrier Cancelled, Declined or Refused to Renew any Insurance in the past 3 years? Yes / No

If so please provide Dates, Coverage & Explanation: _____

Property and Location Information:

Loc No. _____ Address: _____

Limit of Building Insurance: \$ _____ Limit of Insurance for Personal Property: \$ _____

Co Ins: \$ _____

Construction Type: 1-wood frame 2-Masonry wood-joisted 3-metal non-combustible 4-masonry non-combustible
5-modified fire resistive 6-heavy fire resistive

Occupancy Type: 1-retail 2-office 3-warehouse other (describe) _____

Do you: Own Lease

Year Built: _____ Building Square Footage: _____ Square Footage you Occupy: _____

Burglar Alarm: Yes / No Sprinkler System: Yes / No

Burglar Alarm: Manufacture: _____ Certificate No. _____

Monitoring Service: _____

Fire Extinguishers: Yes / No How many on premises? _____ Safe (describe): _____

CGL Limits of Insurance

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	
Damage to Rented Premises:	\$100,000	Other: _____	

Medical Equipment Services & Receipts

Please describe all products sold & leased by you! (in space below, please attach extra sheet in needed).

Total estimated receipts for the next 12 months \$ _____

Percentage (%) of above receipts For the following services:	Home Use	Hospital Use	Non-Disposable Items	Disposable Items
Rental Receipts:	Y / N	Y / N	_____%	N/A
Sales –Retail:	Y / N	Y / N	_____%	_____%
Sales-Distributor/Wholesale:	Y / N	Y / N	_____%	_____%
Sales-Drug Store Pharmaceutical:	Y / N	Y / N	_____%	_____%
Sales-Medical Gases: (high pressure or liquefied)	Y / N	Y / N	N/A	_____%
Other (describe):	Y / N	Y / N	_____%	_____%
Equipment Repair Receipts (other than your equipment)	Y / N	Y / N	_____ %Parts	_____ %Labor

Do you carry any other high tech equipment other than listed above? Y / N
If yes, please provide types and numbers of each:



Do you now offer any of the following services, or have plans to do so in the future?

Servicing/repairing life support equipment including anesthesia ventilators life function monitors, defibrillators, or testing
Equipment or stimulators for this equipment? Y / N

If yes, please explain: _____

Installation of medical gas piping or regulators relating to piping installation? Y / N

If yes, please explain: _____

Compressed Medical Gases

Do you provide compressed medical gases to your customers? Y / N

If yes, what gases? _____

Are you registered with the Federal Food and Drug Administration? Y / N

Have you ever been cited or fined for non-compliance with the Federal Food and Drug Administration Compressed
Medical Gases Guidelines? Y / N

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? Y / N
- Instruct the patient and/or caregiver as to the safe handling of the units? Y / N
- Post "Oxygen in Use" signs in conspicuous places and warn patients and/or caregiver of the fire hazard? Y / N
- Have a check-off sheet indicating the information that was reviewed with the patient and/or caregiver? Y / N
- Perform repairs and calibrations per manufactures' recommendations and at manufactures' specified Intervals? Y / N
- Have a follow-up program to check the equipment in the field at regular intervals? Y / N

Explain any "No" answers: _____

Chemotherapy

Percentage of Total Receipts? _____%

Number of customers per year? _____

Installations & Repairs

Do you install, service or repair vertical lifts, stair lifts or wheelchair lifts? Y / N

Do you install, service or repair motor vehicle hand controls? Y / N

Do you set up ventilators in customers' homes? Y / N

Do you install, service or repair any other medical device used for therapy, support, or assistance that attaches to a vehicle, or to a wall, floor, or ceiling? Y / N

Do you install grab bars? Y / N

Professional Employees & Subcontractor Information

Do you now offer any nursing service or have plans to do so in the future? Y / N

Do you use other certified professionals? Y / N

Prior Insurance Record

Coverage	Policy Term	Insurance Company	Policy #	Liability Limit	Premium	Claims Made Retro Date
General Liability	_____	_____	_____	\$_____	\$_____	_____
General Liability	_____	_____	_____	\$_____	\$_____	_____

General Liability	_____	_____	_____	\$ _____	\$ _____	_____
Professional Liability	_____	_____	_____	\$ _____	\$ _____	_____
Professional Liability	_____	_____	_____	\$ _____	\$ _____	_____
Professional Liability	_____	_____	_____	\$ _____	\$ _____	_____
Property	_____	_____	_____	\$ _____	\$ _____	_____
Property	_____	_____	_____	\$ _____	\$ _____	_____
Property	_____	_____	_____	\$ _____	\$ _____	_____

Application Signatures & State Fraud Statements

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.

Applicant's Signature: _____ **Date:** _____

APPLICABLE IN NEW YORK – NEW YORK CLAIMS-MADE INSURANCE NOTICE

IF LIABILITY COVERAGE IS PROVIDED ON A CLAIMS-MADE BASIS THEN LIABILITY COVERAGE IS LIMITED TO LIABILITY FOR ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST AN INSURED AND REPORTED IN WRITING WHILE THIS POLICY IS IN FORCE, DURING A RENEWAL OF THIS POLICY, OR DURING ANY EXTENDED REPORTING PERIOD. VARIOUS PROVISIONS IN THIS COVERAGE MAY RESTRICT COVERAGE. PLEASE READ THE ENTIRE POLICY CAREFULLY TO DETERMINE RIGHTS, DUTIES, AND WHAT IS AND IS NOT COVERED.

Applicant's Signature: _____ **Date:** _____

Print Name: _____

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR ANOTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL HTERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS THE PERSON TO CRIMINAL AND CIVIL PENALTIES.

THE UNDERSIGNED REPRESENTS THE HE/SHE HAS MADE A GOOD FAITH EFFORT TO ASCERTAIN COMPLETE AND ACCURATE ANSWERS TO THE QUESTIONS SET FOURTH IN THIS SURVEY AND THAT THE INFORMATIONPROVIDED IN THIS SURVEY, INCLUDING ANY ATTACHMENTS, IS TRUE AND ACCURATE AND COMPLETE TO THE BEST OF THEIR KNOWLEDGE AND BELIEF. THE UNDERSIGNED UNDERSTANDS THAT WITHHOLDING RELEVANT INFORMATION OR SUBMITTING FLASE INFORMATION IN COMPLETING THIS APPLICATION FOR INSURANCE COULD VOID ANY INSURANCE BINDER, POLICY OR CERTIFICATE ISSUED AS A RESULT OF THIS APPLICATION.

COMPLETION OF THIS APPLICATION DOES NOT BIND COVERAGE.