NEW ENGLAND EXCESS EXCHANGE

P.O. Box 650 • 57 Parker Rd. • Barre, VT 05641 • 800-548-4301 • www.neee.com

ORTHOTICS AND PROSTHETICS SERVICES APPLICATION SUPPLEMENTAL

1. Proposed First Named Insured & Other Named Insured(s):

2. Mailing Address — Street | City | County | State | ZIP Code

3. Location Address — Street | City | County | State | ZIP Code

4. Telephone: | Fax:

5. Contact person/phone #: | Inspection: | Accounting/Records:

BUSINESS INFORMATION

1. Business Type: ☐ Individual ☐ Partnership ☐ Corporation ☐ LLC ☐ Trust ☐ Other (specify):
2. Operating as: ☐ For Profit ☐ Nonprofit ☐ Other:
3. Interest of Named Insured in premises: ☐ Owner ☐ General Lessee ☐ Tenant ☐ Other:
4. Part occupied by Named Insured: ☐ Entire ☐ Portion (%) ☐ Other (Lessor's Risk Only)
5. Date business established: If new venture, provide prior experience:
6. Describe all business operations conducted by applicant:
7. List key management personnel:

Name	Age	Job Description	Length of Employment	% of Ownership

		Yes	No
8.	Is your business a subsidiary or division of another company? If yes, indicate: Name of Company: Address: Relationship:	☐	☐
9.	Has your business had any changes in ownership over the past 3 years? If yes, provide details:	☐	☐
10.	Do you sponsor any sporting teams or events? If yes, provide details:	☐	☐

PREVIOUS INSURER & LOSS HISTORY – Attach separate sheet if necessary ☐ **See Loss Runs Attached**

Missouri Applicants: **DO NOT** answer this question.

Has insurance of this type been cancelled, refused, or nonrenewed by any company during the past 3 years?

☐ No ☐ Yes – If Yes, give name of company, date, and reason:

Year	Carrier	Policy Number	Coverage	Check if Claims-Made	Premium
				☐	
				☐	
				☐	
				☐	

GENERAL LIABILITY COVERAGE

☐ General Aggregate	$
☐ Products/Completed Operations Aggregate Limit	$
☐ Each Occurrence	$
☐ Damage to Premises Rented to You	$
☐ Medical Payments	$

ORTHOTICS & PROSTHETICS SERVICES AND RECEIPTS

Service Type	Description	Percentage
Patient Care Sales	Includes all sales of items you fabricate, alter or fit.	%
Distributor/Wholesale	Includes all items purchased from others that you resell to other facilities.	%
Sales-Distributor/Wholesale	Items manufactured by you and sold to others for distribution. No patient contact.	%
Durable Medical Equipment	Includes items you sell or rent directly to patients with no altering or re-labeling.	%

Enter sales figures for each of the following operations:

a. Orthotic and Prosthetic manufacturing, fabrication and fittings	$
b. Wholesale distribution of **new** medical equipment	$
c. Wholesale distribution of **used** medical equipment	$
d. Retail distribution of **new** medical equipment	$
e. Retail distribution of **used** medical equipment	$
f. Do you offer Physical Therapy services? ☐ Yes ☐ No	
g. Wholesale distribution of pharmaceuticals	$
h. Retail distribution of pharmaceuticals	$
i. Rental of medical equipment	$
j. Other than listed above:	$
k. Other than listed above:	$

PROFESSIONAL EMPLOYEE AND SUBCONTRACTOR INFORMATION

1. Do you use certified professionals? ☐ Yes ☐ No

   If yes, indicate the total number of people for each category that you use in your business:

	Certified Prosthesis	Fitter	Pedorthist	Physical Therapist	Other (describe)
Employee					
Independent Contractor					

2. Average number of subcontracted professionals used in any one day:

3. Are employers and/or subcontractors ABC or BOC certified? ☐ Yes ☐ No

OPERATIONS

		Yes	No
1.	Is your facility ABC or BOC accredited?	☐	☐
2.	Do you import directly from any foreign manufacturers? If yes, provide certificates of insurance evidencing foreign manufacturer's products liability insurance.	☐	☐
3.	In U.S. dollars, indicate limit of their products liability insurance: $		
4.	Do you obtain certificates of insurance for products liability insurance from U.S. manufacturers of your products? If yes, provide copies of certificates.	☐	☐
5.	Are you a "vendor" on the Products Liability insurance carried by the U.S. manufacturers of your products? *Broad form Vendors Liability should be in place with all manufacturers for products that you rent or sell.	☐	☐
6.	Do you provide professional services to patients without a physician's referral?	☐	☐
7.	Are any products of others sold, repackaged or assembled under your label? If yes, explain:	☐	☐
8.	Are you involved in the sale, rental and/or service of any home medical equipment? If yes, indicate % of sales: %	☐	☐
9.	Do you offer any home infusion therapy? If yes, describe:	☐	☐
10.	Do you manufacture pharmaceuticals? If yes, indicate products:	☐	☐
11.	Do you manufacture medical supplies? If yes, indicate products:	☐	☐
12.	Do you repair equipment? If yes, describe:	☐	☐
13.	Do you manufacture or repair life-sustaining equipment, ambulance/emergency or sanitizing equipment (i.e. pacemakers, ventilators, dialyzers, defibrillators, etc.)? If yes, provide details:	☐	☐
	If yes, are your technicians trained by the manufacturer or bio-medical school?	☐	☐
14.	Are you currently under or having had warning, suspension, revocation or other restrictions due to failure to comply with licensing standards and/or safety codes? If yes, explain:	☐	☐

FRAUD STATEMENTS

FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim of an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

LOUISIANA and MAINE: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Refer to the Core Application for all Fraud Statements.

IMPORTANT NOTICE
DECLARATION

I DECLARE THAT THE STATEMENTS MADE IN THIS PPLICATION ARE COMPLETE AND TRUE.

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

SIGNATURES

Applicant Signature	Title	Date
Producer Signature		Date
Producer Name and Address		