PHILADELPHIA INSURANCE COMPANIES
A Member of the Tokio Marine Group
One Bala Plaza, Suite 100
Bala Cynwyd, PA 19004

HOME MEDICAL DEALERS PROGRAM - ORTHOTICS & PROSTHETIC SUPPLEMENTAL APPLICATION

Pages 1 –) must be completed.

Would Applicant like a quote for Abuse & Molestation? Yes No If yes, please complete section V on page Î .
Would Applicant like a quote for Automobile? Yes No If yes, please complete section VI on page Î .

Applicant Name:
DBA:
(If more than one entity/subsidiary, please attach description and % owned for each)

For Profit Non-Profit Partnership Other (specify):

Address:
City: State: Zip:
Telephone: Fax:
Date business established: # of years under present management:
Federal Employer Tax I.D. Number:
Website address (if available):
Name and phone number of person to contact for inspection:

SUBMISSION REQUIREMENTS

- PHLY Home Orthotics & Prosthetic Supplemental Application
- ACORD Applications (Applicant Information, including Crime and Umbrella)
- Currently valued insurance company loss runs for the current policy period and four prior years

SECTION I - APPLICANT INFORMATION

1. Limits of liability desired:
   $500,000/$1,000,0000 $1,000,000/$1,000,000 $1,000,000/$2,000,000 $1,000,000/$3,000,000
   Other: $ Occurrence / $ Aggregate
2. Has the Applicant ever carried insurance that was on a Claims Made basis? Yes No
   If yes, what is the Retro Date?
3. Total annual Gross Revenues: $
   Total receipts from Retail: $
   Total receipts from Rentals: $
   Total receipts from Wholesale: $
   Total receipts from Professional Services: $

SECTION II - GENERAL LIABILITY AND PROFESSIONAL LIABILITY INFORMATION

1. Please indicate the estimated annual sales (reimbursements) for each of the following types of operations:

Description	Location # 1 Estimated Annual Sales	Location #2 Estimated Annual Sales	Location #3 Estimated Annual Sales
Practitioner Patient Care: includes all items the Applicant makes, fits, alters or adjusts for individual patients.	$	$	$
Manufacturing: includes items manufactured by Applicant and sold to distributors or facilities. No patient contact.	$	$	$
Wholesale Distribution: includes all items purchased from others that Applicant resells to another facility or distributor.	$	$	$
Retail Countersales: includes items sold directly to customers with no alteration or re-labeling. Includes but is not limited to crutch tips, stump socks, shoes, etc.	$	$	$
Other- describe:	$	$	$

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2. a. Please indicate if the Applicant manufactures, distributes, sells or rents any of the following products by checking Yes or No. If the Applicant checks yes, please indicate the annual sales for that product.

	Yes	No	Annual Sales
Drugs, antibiotics, chemicals and apparatus used to administer them			$
Electrical equipment, Transcutaneous Electric Nerve Stimulators, etc.			$
Equipment or devices that pierce the skin or are implanted			$
Exercise equipment			$
Halos and Cranial Devices If yes, who performs attachment of these devices? Patient Physician O&P Practitioner			$
Hoists, lifts, ramps, glides and related equipment			$
Monitoring devices or diagnostic equipment			$
Orthotic/prosthetic devices primarily sold to sports professionals			$
Oxygen, respiratory support systems, respirators, etc			$
Surgical equipment			$
Traction and related equipment			$
Vehicle control devices			$
Wheelchairs			$

b. Please provide a specific description for any “Yes” responses indicated in question 2a. above and include product brochures with Applicant's submission.

c. Does the manufacturer supplying the equipment or devices provide the Applicant with vendor's coverage? Yes No

d. Does the Applicant replace the manufacturers label with theirs on any wholesale or retail products the Applicant distributes? Yes No

e. Does the Applicant perform maintenance and repair of the equipment themself? Yes No

3. Does the Applicant obtain certificates of insurance from manufacturers and distributors who supply the Applicant with component parts for the orthotic and prosthetic devices that the Applicant fabricates? Yes No

4. Are any products or supplies imported from other countries? Yes No
If yes, on a separate sheet please indicate what type of supplies or products and from which countries.

5. Does the Applicant use any independent contractors for their business (1099)? Yes No

6. Does the Applicant employ contract or subcontract labor for service or repair of products? Yes No

7. Does the Applicant render professional services directly to patients without physician referral? Yes No

8. Does the Applicant perform or assist in any surgical procedures? Yes No

9. Have there been any claims filed or losses paid, or is the Applicant aware of any incidents which might give rise to a suit against them, within the last three (3) years? (Please attach prior carrier loss history) Yes No

10. If the Applicant answered yes to any of the questions above, please explain:

11. Have any claims / suits been made within the last five years against the Applicant? Yes No
If yes, please attach copy of insurance company loss reports for each claim or suit. (Specify date, description, amount paid and amount outstanding for each claim).

12. Is the Applicant aware of any circumstances which may result in any claim or suit made (including request for medical records)? Yes No
If yes, please explain:

13. Has any company declined, canceled or refused to renew any of the Applicant’s Professional Liability Insurance? Yes No
If yes, please explain:

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14. Previous Professional Liability Insurance (past five years):

Company	Limits of Liability	Effective Dates	Annual Premium	Claims Made Form or Occurrence Form	Retroactive Date (Claims Made only)
			$		
			$		
			$		
			$		
			$		

15. Limits of Liability Desired:
$500,000/$1,000,000 $1,000,000/$1,000,000 $1,000,000/$2,000,000 $1,000,000/$3,000,000
Other: $ Occurrence / $ Aggregate
16. Is the Applicant a member of any State Association? Yes No
If yes, please provide the name of the State Association:
17. Please indicate if the Applicant is a member of any of the following associations:
American Orthotic and Prosthetic Association Yes No
American Academy of Orthotics and Prosthetics Yes No
Pedorthic Footwear Association Yes No
Other- Describe: Yes No
18. Please indicate the number of staff employed in each of the following capacities, number of years employed with the Applicant, and the number of individuals that are certified by The American Board for Certification in Orthotics, Prosthetics and Pedorthics (ABC) or Board of Certification/Accreditation, International (BOC):
(Please send copies of certification.)

POSITION	# EMPLOYED	YEARS EMPLOYED	# CERTIFIED
Practitioner			
Assistant			
Fitter			
Technician			
Physical Therapist			

19. Please indicate which of the employees identified in question #4 above, are involved in continuing education:
20. Please indicate if Applicant's business is accredited or certified by: ABC BOC Other:
21. Please indicate the % of orthotic and prosthetic devises that are fabricated by the following:
Employed Practitioners % Employed Fitters %
Employed Assistants % Central Fabricating Facilities %
Employed Technicians % Other: %

SECTION III - PROFESSIONAL LIABILITY HIRING / SCREENING

1. Are all employees and contractors screened to rule out drug, alcohol and sexual abuse? Yes No
2. Check all methods used in hiring all employees or independent contractors:
   - Drug Testing Yes No
   - Criminal Background Checks – Federal Yes No
   - Criminal Background Checks – State Yes No
   - Reference Checks Yes No
   - Personal Interview Yes No
   - Sexual Abuse Registry Yes No
   - Validate Work History Yes No
   - Validate Education Yes No
   - Verify Current Certification / Professional License Yes No
   - Validate Driver's License Yes No
   - Validate Personal Auto Insurance and Limits (if operating owned vehicle during company hours) Yes No
3. How are references checked: Written Verbal Both
If verbal only, please explain:

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4. Are all of the above methods done prior to hiring? Yes No
   If “no”, please explain:

5. Are job descriptions provided for all professional and nonprofessional employees? Yes No
6. Does the Applicant verify certificate and / or professional licensure status of employees and independent contractors? Yes No
7. What is the average staff turnover rate: %
8. Does the Applicant question prospective employees about any previous involvement as defendants in professional malpractice litigation? Yes No
   If no, please explain:

9. Does the Applicant verify if potential employees and or independent contractors have ever had their license revoked or suspended, or disciplinary action taken against them? Yes No

SECTION IV - PROFESSIONAL LIABILITY RISK MANAGEMENT

1. Does the Applicant utilize a formal written Quality Assurance Risk Management Program? Yes No
   If no, please explain:

2. Does the Applicant verify certificate and / or professional licensure status of employees and independent contractors? Yes No
3. Are employees required to carry their own individual professional liability coverage? Yes No
   Limits of Liability: $
4. Are independent contractors required to carry their own individual professional liability coverage? Yes No
   Limits of Liability: $
5. Are certificates of insurance maintained on file for all employees and independent contractors and updated annually? Yes No
6. Does the Applicant have formal HIPAA compliance procedures in place? Yes No
7. Has the Applicant developed written protocols that govern the admission and medical treatment of patients for the following policies and procedures:
   a. Complete treatment plan prescribed by the physician, including follow up plans? Yes No
   b. Assessments of clients prior to and after accepting the clients? Yes No
   c. Client’s care and home visits documented? Yes No
   d. Documentation of all homecare training? Yes No
   e. All changes in the condition of the client or incidents involving the client documented in the records and reported to the family and physician? Yes No
8. Is the overall responsibility for Risk Management assigned to one individual in Applicant's organization? Yes No
   If yes, please list name and title:
   If no, please describe how these functions are monitored:

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FRAUD STATEMENT AND SIGNATURE SECTIONS

The Undersigned states that he/she is an authorized representative of the Applicant and declares to the best of his/her knowledge and belief and after reasonable inquiry, that the statements set forth in this Application (and any attachments submitted with this Application) are true and complete and may be relied upon by Company * in quoting and issuing the policy. If any of the information in this Application changes prior to the effective date of the policy, the Applicant will notify the Company of such changes and the Company may modify or withdraw the quote or binder.

The signing of this Application does not bind the Company to offer, or the Applicant to purchase the policy.
***Company refers collectively to Philadelphia Indemnity Insurance Company and Tokio Marine Specialty Insurance Company**

FRAUD NOTICE STATEMENTS

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE 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 THAT PERSON TO CRIMINAL AND CIVIL PENALTIES (IN OREGON, THE AFOREMENTIONED ACTIONS MAY CONSTITUTE A FRAUDULENT INSURANCE ACT WHICH MAY BE A CRIME AND MAY SUBJECT THE PERSON TO PENALTIES). (IN NEW YORK, THE CIVIL PENALTY IS NOT TO EXCEED FIVE THOUSAND DOLLARS ($5,000) AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION). **(NOT APPLICABLE IN AL, AR, AZ, CO, DC, FL, KS, LA, ME, MD, MN, NM, OK, RI, TN, VA, VT, WA AND WV).**

APPLICABLE IN AL, AR, AZ, DC, LA, MD, NM, RI AND WV: ANY PERSON WHO KNOWINGLY (OR WILLFULLY IN MD) PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY (OR WILLFULLY IN MD) PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES OR CONFINEMENT IN PRISON.

APPLICABLE IN COLORADO: IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES.

APPLICABLE IN FLORIDA AND OKLAHOMA: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY (IN FL, A PERSON IS GUILTY OF A FELONY OF THE THIRD DEGREE).

APPLICABLE IN KANSAS: AN ACT COMMITTED BY ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO DEFRAUD, PRESENTS, CAUSES TO BE PRESENTED OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, PURPORTED INSURER, BROKER OR ANY AGENT THEREOF, ANY WRITTEN, ELECTRONIC, ELECTRONIC IMPULSE, FACSIMILE, MAGNETIC, ORAL, OR TELEPHONIC COMMUNICATION OR STATEMENT AS PART OF, OR IN SUPPORT OF, AN APPLICATION FOR THE ISSUANCE OF, OR THE RATING OF AN INSURANCE POLICY FOR PERSONAL OR COMMERCIAL INSURANCE, OR A CLAIM FOR PAYMENT OR OTHER BENEFIT PURSUANT TO AN INSURANCE POLICY FOR COMMERCIAL OR PERSONAL INSURANCE WHICH SUCH PERSON KNOWS TO CONTAIN MATERIALLY FALSE INFORMATION CONCERNING ANY FACT MATERIAL THERETO; OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO.

APPLICABLE IN MAINE, TENNESSEE, VIRGINIA AND WASHINGTON: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.

APPLICABLE IN NEW YORK: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATOIN 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 BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATE VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

NAME (PLEASE PRINT/TYPE)

TITLE
(MUST BE SIGNED BY THE PRESIDENT, CHAIRMAN, CEO OR EXECUTIVE DIRECTOR)

____
SIGNATURE

DATE

SECTION TO BE COMPLETED BY THE PRODUCER/BROKER/AGENT

PRODUCER
(If this is a Florida Risk, Producer means Florida Licensed Agent)

AGENCY

PRODUCER LICENSE NUMBER
(If this a Florida Risk, Producer means Florida Licensed Agent)

ADDRESS (STREET, CITY, STATE, ZIP)

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SECTION V - ABUSE AND MOLESTATION

1. Does the Applicant current insurance program include Abuse and Molestation coverage? Yes No
   If yes, what are the limits? $
2. Does the Applicant's employment process include verification of whether the individual has ever been convicted of any crime, including sex related or child-abuse related offenses, before an offer of employment is made? Yes No
3. Does the Applicant have a written crisis plan in place for dealing with employees, victims, parents, authorities, and the media if the Applicant has an incident of abuse? Yes No
4. Are there written complaint procedures and are they displayed prominently? Yes No
   If no please explain:
5. Are there written procedures that monitors staff in day-to-day relationships with clients, both on and off premises? Yes No
6. Is there formal staff training on sexual abuse, including how to recognize the signs? Yes No
7. Is there more than one person responsible for the welfare of any single patient? Yes No
8. Have any incidents resulted in an allegation of sexual abuse? Yes No
9. Was the case settled? Yes No
10. Was the case taken to trial? Yes No
11. Amount paid for damages to the victim: $
12. Does the Applicant provide equipment, services or therapy to minors? Yes No

SECTION VI - AUTO INFORMATION

1. Does the Applicant own or lease any vehicles? Yes No
2. Does the Applicant need coverage for non-owned automobiles? Yes No
3. Does the Applicant have a program to monitor an employee's personal auto liability insurance program?
   a. At time of hire? Yes No
   b. Annually? Yes No
4. Does the Applicant run MVRs on all employees?
   a. At time of hire? Yes No
   b. Annually? Yes No
   c. Randomly (based on accidents or suspicions) Yes No
5. What action is taken if an "unacceptable" driver is identified?
6. Do all Applicant's employees or volunteers transport clients in their own automobiles (appointments or errands)? Yes No
7. Does the Applicant transport non-ambulatory clients? Yes No
8. Does the Applicant contract with an ambulance or livery service to transport clients? Yes No
9. How many drivers use personal vehicles for business? F/T*: P/T**: Vol.:
   *F/T = Full Time – over 20 hours per week
   **P/T = Part Time – up to 20 hours per week
10. What is the maximum and minimum age of drivers allowed to drive clients? Max: Min:
11. Does the Applicant allow personal use of a company-owned vehicle? Yes No
12. Does the Applicant make sure travel logs are kept for all drivers? Yes No

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