



PROFESSIONAL and GENERAL LIABILITY APPLICATION DURABLE MEDICAL EQUIPMENT (Edition 06.2026)

Section 1: Applicant Information

1. Applicant Name: _____
2. Mailing Address: _____
3. Location Address: _____
(If multiple names and locations, please attach list)
4. Telephone Number: _____ Website Address: _____ Date Established: _____

Section 2: Business Details

5. Entity Type: ☐ Corporation ☐ Individual ☐ LLC ☐ Partnership ☐ Other: _____
6. Status: ☐ For Profit ☐ Non-Profit
7. Funding is: Medicare _____% Medicaid _____% Private Pay _____% Other: _____

Section 3: Coverage Requested

8. Effective Date: _____
9. Liability Limits: \$ _____ / \$ _____
10. Deductible: \$ _____

Section 4: Financials

11. Total Gross Receipts (Past 12 Months): \$ _____
 - a) Revenues from Sales: _____%
 - b) Revenues from Rentals: _____%
12. Estimated Gross Receipts (Next 12 Months) \$ _____
 - a) Revenues from Sales: _____%
 - b) Revenues from Rentals: _____%

Section 5: Description of Operations

13. The applicant is licensed as: _____
14. Full description of services provided: _____
15. Does the applicant have any ancillary operations not stated above? ☐ Yes ☐ No
If Yes, please provide details: _____
- If Yes, does the applicant maintain separate professional and general liability coverage for these operations with limits equal to or greater than those specified in Section 3 of this application? ☐ Yes ☐ No

16. Is the applicant engaged in, owned by, associated with, or controlled by any other businesses? ☐ Yes ☐ No
If Yes, please provide details: _____

If Yes, does the applicant maintain separate professional and general liability coverage for these operations with limits equal to or greater than those specified in Section 3 of this application? ☐ Yes ☐ No

17. Does the applicant have any international sales? ☐ Yes ☐ No
If Yes, please estimate the percentage: _____%

Section 6: Supplier & Controls

18. Do you directly import any products or component parts? ☐ Yes ☐ No
If Yes, please attach a complete list of imported products or parts including the percentage of total sales, manufacturer, and country of origin.

19. Do you obtain Certificates of Insurance including coverage for Products Liability from each of your suppliers?
a) Are you listed as an Additional Insured on these policies, or do you require proof of a blanket Additional Insured Vendor endorsement? ☐ Yes ☐ No
b) What minimum limits do you require? \$_____ / \$_____

20. Do you design your products? ☐ Yes ☐ No
If No, who designs your products? _____

21. Are designs reviewed, tested, and verified by an independent third party? ☐ Yes ☐ No

22. Are all warning labels, instructions, and advertising material reviewed by outside counsel? ☐ Yes ☐ No

23. Do your products meet applicable government or industry standards? ☐ Yes ☐ No

24. If it becomes necessary to recall a product, do you have a documented product recall plan in place? ☐ Yes ☐ No
a) Do you currently maintain Product Recall insurance? ☐ Yes ☐ No
b) Are there established procedures in place to secure the return and proper disposal of recalled products? ☐ Yes ☐ No

25. Please indicate the type(s) of clients to whom the applicant sells and/or rents products.
Check all that apply and indicate the approximate percentage of revenue attributable to each (Total should equal 100%):

- ☐ Individuals using products in their private residences _____%
- ☐ Individuals residing in nursing homes or similar residential care facilities _____%
- ☐ Clinics and/or laboratories _____%
- ☐ Hospitals _____%
- ☐ Physicians or physician practices _____%
- ☐ Other (please describe): _____%

Section 7: Equipment Sold or Rented

26. Please indicate the percentage of the following medical equipment/devices that are sold and/or rented:
(Percentages should total 100%)



Device	% Sold	% Rented	Device	% Sold	% Rented
ADL Device			Motorized Scooters		
Apnea Monitor			Motorized Wheelchairs		
BiPAP Device			Nebulizer		
Canes			Non-Motorized Wheelchairs		
CPAP Device			Orthotics		
CPM Device			Oxygen Concentrators		
Crutches			Oxygen Cylinders		
Defibrillators			Oxygen Ventilators		
Diabetic Supplies			Parenteral Therapy		
Disposables			Prosthetics		
Electric Beds			Safety Bars		
Endoscopes			Safety Harnesses		
Gloves			Stair/Ceiling Lifts		
Hoyer Lift			TEN Units		
Lasers			Walkers		
Lift Chairs			Wheelchair Lifts		
Manual Beds			Other (Describe):		

27. Do you perform installation, services, or repair services?

☐ Yes ☐ No

If Yes, describe operations: _____

a) What is the percentage of total revenue from installation/service/repair: _____%

b) Is maintenance performed by manufacturer guidelines?

☐ Yes ☐ No

c) Factory-trained personnel only?

☐ Yes ☐ No

d) Are subcontractors used?

☐ Yes ☐ No

If Yes, are COIs collected prior to work?

☐ Yes ☐ No

28. Are any of your products currently being used in a clinical trial or in any other tests involving human subjects?

☐ Yes ☐ No

If Yes, please attach details regarding the trial(s), test(s), or study(ies).

29. Do you promote any of your products for off-label use?

☐ Yes ☐ No

If Yes, please attach a detailed description including the product(s) involved, the approved use(es), and supporting documentation demonstrating the acceptability of such off-label use.

Section 8: Clinical & Regulatory

30. Have you been inspected by the U.S. Food and Drug Administration (FDA) within the past five (5) years?

☐ Yes ☐ No

If Yes, list the inspection date(s) and any findings. _____

31. Have you received any customer complaints within the past five (5) years? ☐ Yes ☐ No
- If Yes:
- a) Please indicate the number of complaints received: _____
- b) If Yes, provide the inspection date(s), a brief description, and any findings. _____

32. Have any adverse events involving your products been reported to you or to the U.S. Food and Drug Administration (FDA) within the past five (5) years? ☐ Yes ☐ No
- If Yes:
- a) Please indicate the number of adverse events reported: _____
- b) Please attach details of the product(s), complaint(s), and any corrective actions taken.

Section 9: Staffing

33. List the number and type of **EMPLOYEES** and **INDEPENDENT CONTRACTORS**:
(If owner-operated, describe contingency plans in the event of owner unavailability)

	EMPLOYEES	CONTRACTORS		EMPLOYEES	CONTRACTORS
Registered Nurse			Nurse Practitioner		
Respiratory Therapist			Occupational Therapist		
LPN/ LVN			Physical Therapist		
Physical Therapist			Physician (No patient contact)		
CNA			Physician (Patient contact)		
Physician Assistant			Clerical / Administrative		
Medical Technician			All Others (Describe):		

- a) Are all individuals listed on Q33 subject to licensing requirements properly licensed? ☐ Yes ☐ No
- If No, explain: _____
34. Are you seeking coverage under this proposed insurance for the independent contractors? ☐ Yes ☐ No
- If No, is coverage at equal or greater limits maintained by each independent contractor? ☐ Yes ☐ No
35. Do you require employed physicians, surgeons, nurse anesthetists, dentists, podiatrists or chiropractors to carry their own Professional Liability Insurance and secure Certificates of Insurance as evidence of such coverage? ☐ Yes ☐ No ☐ N/A
- If Yes, at what limits? \$_____ / \$_____
36. Are all services provided at the applicant's location address(s)? ☐ Yes ☐ No
- If No, please provide details of any off-site exposure: _____



37. Screening and Policies:

- a) Do you conduct pre-employment screening and investigation? ☐ Yes ☐ No
- b) Do you have a written incident/occurrence reporting policy and procedures? ☐ Yes ☐ No

38. Check all the following that are collected, verified, and maintained for each staff member during the hiring process:

- ☐ Applications/Resumes ☐ Criminal Background Checks ☐ Licensure Verification
- ☐ Drug Testing ☐ Education/Training/Competence

39. Is the applicant accredited, certified, licensed, or a member of any professional association or governing body? ☐ Yes ☐ No

If Yes, describe: _____

Section 10: Regulatory and Inspection

40. Disclosure of Disciplinary or Legal History:

Attach a detailed explanation for any **YES** answers below:

Has the applicant or have any of the employees:

- a) Ever been subject to disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital, or professional association? ☐ Yes ☐ No
- b) Ever been convicted of any act committed in violation of any law or ordinance (other than traffic offenses)? ☐ Yes ☐ No
- c) Ever been treated for alcoholism or drug addiction? ☐ Yes ☐ No
- d) Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused, accepted only on special terms, or voluntarily surrendered? ☐ Yes ☐ No

Section 11: Insurance History

Currently valued loss runs for all prior coverage are required.

41. Professional Liability Coverage – Last 5 Years: (If none, state none)

Carrier	Limit	Deductible	Premium	Expiration (MM/DD/YYYY)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

If expiring insurance is a **claims-made** policy, provide retroactive date: _____



42. General Liability Coverage – Last 5 Years: (If none, state none) _____

Carrier	Limit	Deductible	Premium	Expiration (MM/DD/YYYY)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

If expiring insurance is a **claims-made** policy, provide retroactive date: _____

Section 12: Claims and Incidents

43. Has any insurer canceled or refused to renew similar insurance in the past 5 years?
(If Yes, attach details) ☐ Yes ☐ No

44. Has any claim been made against the insured or its employees that would be covered by this
policy in the past 5 years? ☐ Yes ☐ No

If Yes, please attach a completed Huntersure Claims Supplement (one for each claim or incident reported)

45. Is the applicant aware of any circumstances that may result in a claim against the insured or its employees
that would be covered under this policy? (If Yes, attach details) ☐ Yes ☐ No

Signature and Attestation

Application for Claims-Made Professional Liability Insurance

The undersigned declares that to the best of his/her knowledge the statements herein are true. Signing of this Application does not bind the undersigned to complete the insurance, but it is agreed that this Application shall be the basis of the contract should a Policy be issued, and that this Application will be attached and become part of such Policy, if issued. Underwriters hereby are authorized to make any investigation and inquiry in connection with this Application, as they deem necessary.

FOR KENTUCKY RISKS: 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 act, which is a crime.

ELECTRONIC SIGNATURE: If the application is e-signed, it must be accompanied by the verification page or proof that it was securely e-signed along with the date, time stamp, and originating email address.

Name of Applicant: _____
Please Print Title

Signature: _____
Name Date

(NOTE: Application must be signed by the owner or president or principal)

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