PROTEK

MEDICAL EQUIPMENT INSURANCE SOLUTIONS

PROGRAM ADMINISTERED BY THE LEAVITT GROUP

Renewal Date / Effective Date: _____ FEIN (Tax ID #) _____

Business is a: Individual/Sole Proprietor ☐ Partnership ☐ Corporation / S-Corp ☐ LLC ☐ Other ☐ _____

Named Insured(s): _____

_____

Mailing Address: _____

Address **City, State** **Zip**

Principal/Officer(s) Name(s): _____

Renewal Contact Name(s): _____

Phone Number: _____ Cell Phone: _____

Fax Number: _____ Phone Number: _____

Email Address: _____ Website: www._____

DETAILED DESCRIPTION OF ALL OPERATIONS

_____

_____

_____

If physical address is the same as the mailing address check here ☐ then go to question #1

Location 1 Physical Address: _____

Location 2 Physical Address: _____

*If you have more than 2 physical locations, please attach a separate page with the address information

OPERATIONAL INFORMATION

1) Year started business: _____ **If you have been in business less than <u>five</u> years include a resume or bio for each Principal**

2) Number of Employees & Principals Full Time #_____ Part Time #_____ Principal(s) # _____ TOTAL _____

3) Do you provide benefits for your employees? If so, how many employees receive benefits # _____

4) Number of 1099 who only work for your company Sales Reps # ____ Repair Techs # _____ Other #_____

Break down all individuals below who perform medical equipment service, repair, refurbish, install or de-install

5) Number of employee repair tech(s) _____ Total annual repair tech payroll $ _____

6) Total cost of all 1099 repair tech(s) paid annually $_____

7) Total payroll for all employees located **<u>ONLY</u>** in (ND, OH, WA, WY) $_____

8) Number of Principal(s), Owner(s), & Officer(s) that perform repair _____ (do not include in # of employee techs above)

9) Break down your client profile (clients you sell or service equipment for - must total 100%)

Hospitals / Surgery Centers:	_____ %	
Dr. Offices / Clinics / Veterinary:	_____ %	
Schools / Universities	_____ %	
Laboratories:	_____ %	
***Industrial:**	**_____ %**	***Describe: _____**
***Other:**	**_____ %**	***Describe: _____**

Section I – Gross Sales Allocations

Current Annual Total Gross Sales	$

Allocate your estimated upcoming total annual gross sales in categories that only apply to you below.

Your premium is based on your estimated projections at the beginning of each year.

At the end of the policy period you may be audited.

OPERATIONS PERTAINING TO SERVICES PROVIDED		GROSS SALES	
A	Consulting Services for Fee (not included in the sale or repair of a device)	$	
B	Repair, Refurbish or Replacement of Component Parts	$	
C	Medical Gas Verification, Certification & Environmental Monitoring	$	
D	Preventative Maintenance & Service Contracts	$	
E	Install / De-Installation of Medical Equipment, Medical Gas Piping or Devices	$	
F	Devices or Equipment sold which you have Designed, Manufactured or Branded	$	
G	Number of students you train or certify annually for a fee → # of students _____	$	
H	**ALL OTHER: DESCRIBE** _____	$	
OPERATIONS PERTAINING TO SALES OF EQUIPMENT		**US & CANADA GROSS SALES**	**FOREIGN GROSS SALES**
I	Sale of **New** Component Parts **(NOT PART OF REPAIR)**	$	$
J	Sale of **Used** Component Parts **(NOT PART OF REPAIR)**	$	$
K	Sale of **New** Equipment	$	$
L	Sale of **Used** or Refurbished Equipment	$	$
M	Sale of Disposables (one time use)	$	$
N	Sale of Veterinary Equipment	$	$
O	Rental Income of Medical Equipment or Devices	$	$
P	Manufacturers Rep (Drop shipped from manufacturer to buyer) **PROVIDE COMMISSION ONLY**	$	$
Q	Sale of Products Imported from a Foreign Country Not including products imported from Canada or U.S. Territories or Possessions (Do NOT include in ANY categories above)	$	$
R	**ALL OTHER: DESCRIBE** _____	$	$
TOTAL U.S., CANADA AND FOREIGN PROJECTED GROSS SALES		$	

1. If you have any foreign sales (not including Canada) please list the countries you sell to or service equipment for

   _____

2. List Manufacturers of products that you sell or service: **Check here for none** ☐

   _____

3. Do you sell, repair, or rent medical equipment or devices that are used by individuals in their home? YES ☐ NO ☐

   a. If Yes, Explain_____

   b. Percentage of gross sales of equipment sold to the end user? %_____

Section II - Types of Devices

Check all the types of equipment that apply to your operations.
Type I, Type II, Type III & ALL OTHER must total 100% all categories combined

Total % of Type I Equipment ____ / 100%		Total % of Type II Equipment ____ / 100%		Total % of Type III Equipment ____ / 100%	
Cardiopulmonary Bypass Equipment Sell New ☐ Sell Used ☐ Service ☐	☐ ___ %	Anesthesia Equipment	☐	Analytical Equipment	☐
Cobalt Therapy Units Sell New ☐ Sell Used ☐ Service ☐	☐ ___ %	Veterinary Anesthesia Equipment	☐	Computers	☐
Pacemakers Sell New ☐ Sell Used ☐ Service ☐	☐ ___ %	Defibrillators / AED's	☐	Diathermy Equipment	☐
Therapeutic X-Ray Sell New ☐ Sell Used ☐ Service ☐	☐ ___ %	External Defibrillator	☐	Electrosurgical Equipment	☐
Ventricular Assist Devices (VAD's) Sell New ☐ Sell Used ☐ Service ☐	☐ ___ %	Internal Defibrillator	☐	Electrical Safety Testing	☐
		Dialysis Equipment	☐	Laboratory Equipment	☐
Check here if any devices are implantable and list below _____	☐ ___ %	Endoscopes	☐	**Latex** Gloves or Sponges ____ %	☐
		Hospital Beds	☐	Nuclear Medicine Units	☐
		Linear Accelerators	☐	Power Laparoscopic Morcellator	☐
		Neonatal Incubators, Warmers	☐	Sterilizers & Washers	☐
		Ophthalmic Lasers	☐	Surgical / Exam Tables	☐
		Therapeutic Ultrasound	☐	Surgical Instruments	☐
				Surgical Lasers	☐
		Ventilators	☐	Surgical Lights	☐
				Telemetry Equipment (Patient Monitors)	☐
				Transcutaneous Electrical Nerve Stimulation Equipment (TENS)	☐
				Veterinary Equipment	☐
				IMAGING EQUIPMENT – TYPE III	☐
				Catheterization Laboratories	☐
				CT Scanners	☐
				Film Processors	☐
				General Purpose Radiographic Equipment	☐
				MRI Scanners	☐
				Ultrasound Equipment	☐
				***MEDICAL GAS – TYPE III**	☐
				*Environmental Monitoring	☐
				*Medical Gas Certification	☐
				*Medical Gas Install / De-install	☐
				*Medical Gas Verification	☐

LIST BELOW ALL OTHER TYPES OF EQUIPMENT OR BUSINESS OPERATIONS NOT LISTED ABOVE

_____

_____

_____

_____

_____

_____

TOTAL PERCENTAGE OF ALL OTHER TYPE EQUIPMENT: _____ / 100

* REQUIRES MEDICAL GAS SUPPLEMENTAL APPLICATION TO BE COMPLETED

Section III - Subcontracting

1. Do you Subcontract any work to other companies? Yes ☐ No ☐ **If no, skip to Section IV**

Types of work you subcontract out (check all that apply):

Repair ☐ Install/De-install of equipment ☐ Rigging ☐ Delivery of Equipment ☐ Cosmetic Refurbishing ☐ Refurbishing ☐

Medical Gas Certification / Verification ☐ Other ☐ Describe all other: _____

2. Provide the total subcontracted costs you pay annually below (not including delivery of equipment by carriers such as UPS/FEDEX)

a. Total Cost of Subcontractors you collect certificates of insurance from $_____

b. Total Cost of Subcontractors you DO NOT collect certificates of insurance from $_____

3. Do you require the following from subcontractors?

a. Certificates of Insurance with limits equal to yours? Yes ☐ No ☐

b. Additional Insured Status? Yes ☐ No ☐

c. Written Contract with a hold harmless agreement? Yes ☐ No ☐

Note: If you are utilizing subcontractors that do not have insurance you may not qualify for this program. Underwriting may require copies of your subcontractors certificates of insurance, please have available upon request

Section IV - Repair

1. Do you perform any service or repairs? Yes ☐ No ☐ **If no, skip to Section V**
2. Do you replace the OEM (original equipment manufacturer) component parts? Yes ☐ No ☐
   If yes, do you always replace with OEM replacement parts? Yes ☐ No ☐
3. Do you adhere to the OEM (original equipment manufacturer) specifications, or a variation of the same? Yes ☐ No ☐
4. Do you maintain a record of what service was performed? Yes ☐ No ☐
5. What type of a service record do you maintain: Electronic copy ☐ Hard Copy ☐ Both ☐
6. Do you perform cosmetic refurbishing? Yes ☐ No ☐
7. Does your company sell equipment that you refurbished? Yes ☐ No ☐

   If yes, Total Payroll for employee repair techs who only refurbish equipment that you sell **Payroll: $**_____

Section V - Manufacturing

1. Do you Design, Manufacture or Brand any products, medical equipment or devices? Yes ☐ No ☐

Check all that apply: Design ☐ Manufacture ☐ Branding ☐

If yes, list ALL products that your company designs, manufactures or brands with your company name:

_____

2. Do you import any products directly from foreign countries? Yes ☐ No ☐ **(Not Including Canada, U.S. Territories or Possessions)**

If yes, answer a-c below:

a. Gross sales of products imported $ _____

b. Describe sold products imported _____

c. Countries imported from: _____

3. Do you replace the OEM name on any products or devices with your own name? Yes ☐ No ☐

a. If yes, provide the products or devices you're relabeling with your companies name:

_____

b. Provide total gross sales of all products resold with your company's name: $_____

Section VI - Rigging

Rigging – Operations where equipment is suspended by the use of crane or specialized moving equipment.

1. Does your company perform any rigging operations? Yes ☐ No ☐
   a. Number of years experience #_____
   b. Provide details of rigging operations _____
2. Does your company subcontract any rigging operations? Yes ☐ No ☐
   If yes, explain aaa

Note: If you are utilizing subcontractors that do not have insurance you may not qualify for this program. Underwriting may require copies of your subcontractors certificates of insurance, please have available upon request.

Section VII – Company Structure and Prior Claims

1.	Is your company a subsidiary of another company or do you have any subsidiary operations?	YES ☐ NO ☐
2.	Is the legal entity to be Named Insured on this policy involved in any other operations?	YES ☐ NO ☐
3.	Has your company had its General Liability insurance cancelled or non-renewed for any reason during the last 5 years?	YES ☐ NO ☐
4.	Has your company had any General Liability losses during the past 5 years?	YES ☐ NO ☐
5.	Are there any General Liability claims or reserves outstanding?	YES ☐ NO ☐
6.	Have you ever been sued or named in a law suit?	YES ☐ NO ☐

If you answered yes to any of these questions, please explain below

_____
_____
_____

Section VIII - MISC

1.	Does your company or subcontractors <u>demonstrate</u> the use of the device you sell or service on a patient?	YES ☐ NO ☐
2.	Does your company or subcontractors <u>assist</u> in the application of a medical device on a patient?	YES ☐ NO ☐
3.	Does your company or subcontractors provide any <u>training or consulting,</u> other than operation of the device?	YES ☐ NO ☐

If you answered yes to any of these questions, please explain below

_____
_____

Section IX – Hired & Non-Owned Auto

<u>Non-Owned Automobile Liability -</u> Liability protection for autos used in your business that are **<u>NOT</u>** owned, leased, hired, rented or borrowed by a named insured. This includes automobiles of employees and subcontractors that are used on behalf of your business.

<u>Hired Automobile Liability Coverage –</u> Liability protection for the use of vehicles leased, hired, rented or borrowed by you or your employees while in the course of your business.

1. Do you currently have a Commercial Auto Liability Policy? YES ☐ NO ☐
   If yes, confirm with your commercial auto carrier that you already have this coverage and skip this section
2. Do you have vehicles titled to your company? YES ☐ NO ☐
3. Does your company annually review motor vehicle reports for employees who drive for your company? YES ☐ NO ☐
4. Does your company confirm that employees have an active personal auto policy with liability limits of at least $50,000 bodily injury each person? YES ☐ NO ☐

Section X – Prior Carrier

1. Have you carried General Liability Insurance in the past 5 years YES ☐ NO ☐ **If no, skip to # 5**
2. Are you currently insured through PROTEK or Koty-Leavitt? YES ☐ NO ☐ **If yes, skip to # 5**
3. Provide previous liability carriers and indicate if products and completed operations coverage was included:

	Insurance Company	Premium	Expiration date	Includes Products?
Current				YES ☐ NO ☐
Year 2				YES ☐ NO ☐
Year 3				YES ☐ NO ☐
Year 4				YES ☐ NO ☐

4. If you currently have a claims made policy, what is the retro date? ____/____/_____ ***Provide copy of declarations page**
5. Check here if you would like higher limits than 1 MIL / 3 MIL ☐ DESIRED LIMIT: _____

   If you need higher limits than 1/3 a separate quote for an excess policy will be provided.

Section XI – Optional Coverages

1. Do you currently have Excess Liability / Umbrella Policy? YES ☐ NO ☐ Check here for a quote ☐
   Carrier Name: _____ Renewal Date: ____/____/____
2. Do you currently have Workers Compensation? YES ☐ NO ☐ Check here for a quote ☐
   Carrier Name: _____ Renewal Date: ____/____/____
3. Do you currently have Property coverage? YES ☐ NO ☐ Check here for a quote ☐
   Carrier Name: _____ Renewal Date: ____/____/____
4. Do you currently have a Commercial Auto Policy in effect? YES ☐ NO ☐ Check here for a quote ☐
   Carrier Name: _____ Renewal Date: ____/____/____

Notes To Underwriting

NOTICE TO APPLICANTS: 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 ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO ARKANSAS, NEW MEXICO AND WEST VIRGINIA APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT, OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

NOTICE TO COLORADO APPLICANTS: 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 AUTHORITIES.

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

NOTICE TO FLORIDA APPLICANTS: 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 OF THE THIRD DEGREE.

NOTICE TO KANSAS APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD, PRESENTS, CAUSES TO BE PRESENTED OR PREPARED WITH KNOWEDLGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, PURPORTED INSURER, BROKER OR ANY AGENT THEREOF, ANY WRITTEN 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 MATERIAL FALSE INFORMATION CONCERNING ANY FACT MATERIAL THERETO; OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT.

NOTICE TO KENTUCKY APPLICANTS: 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.

NOTICE TO LOUISIANA APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

NOTICE TO MAINE APPLICANTS: 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.

NOTICE TO MARYLAND APPLICANTS: ANY PERSON WHO KNOWINGLY AND WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY AND WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

NOTICE TO MINNESOTA APPLICANTS: A PERSON WHO FILES A CLAIM WITH INTENT TO DEFRAUD OR HELPS COMMIT A FRAUD AGAINST AN INSURER IS GUILTY OF A CRIME.

NOTICE TO NEW JERSEY APPLICANTS: ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO NEW YORK APPLICANTS: 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.

NOTICE TO OHIO APPLICANTS: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

NOTICE TO OKLAHOMA APPLICANTS: WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY (365:15-1-10, 36 §3613.1).

NOTICE TO OREGON APPLICANTS: 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 ACT, WHICH MAY BE A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO PENNSYLVANIA APPLICANTS: 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 SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO TENNESSEE, VIRGINIA AND WASHINGTON APPLICANTS: 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.

NOTICE TO VERMONT APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE STATEMENT IN AN APPLICATION FOR INSURANCE MAY BE GUILTY OF A CRIMINAL OFFENSE AND SUBJECT TO PENALTIES UNDER STATE LAW.

_____

Signature of Owner, Partner, Member, Principal, or Officer Authorized to Sign as Applicant

Applicant's Printed Name: _____

Title: _____

Date: _____

Please Email or Fax completed form to FAX # (520) 571-9667.