



G.F. Mann Agency, Ltd.

INTERNATIONAL ASSOCIATION OF MEDICAL EQUIPMENT DEALERS
Commercial Insurance Application

Firm's Name: _____ Year Founded: _____

___ Proprietorship ___ Corporation ___ Partnership ___ Joint Venture ___ Subsidiary

Address:

Contact Person: _____ Phone: _____

Title: _____ Effective Date: _____

Provide a brief overview of your operations:

Please attach copies if any marketing brochures or literature that you have available.

SALES INFORMATION

<u>Source of Revenue</u>	<u>Est. Next 12 Months</u>	<u>Prior Year</u>
Medical Equip. Sales – US*		
Medical Equip. Sales – Foreign*		
Consumables/Supplies - Retail		
Service/Maintenance		
Installations		
Other - Describe		

*Or foreign manufacturers with wholly owned US subsidiaries

Attach copy of most recent financial statement – If available – New Business – Required

A. NON-MANUFACTURING SALES _____ Not Applicable

Check all products your firm sells manufactured by others:

___ Diagnostic Radiographic Imaging Systems

___ Magnetic Resonance Imaging Systems

___ Ultrasonic Imaging Systems

___ Therapeutic Radiation Systems

___ EKG/EEG

___ Other: List or check on supplemental list attached

Are any of the devices sold by your firm FDA Class III devices?

Yes – (specify) _____
 No

Do you sell any products manufactured by a foreign supplier not domiciled in the US?

Yes – (specify) _____
 No

Are any products manufactured by others, but sold under your name?

Yes – (specify) _____
 No

If **YES**, do you require:

Vendors Coverage? Yes No

Certificates of Insurance? Yes No

Favorable Hold Harmless? Yes No

Do you lease any equipment on a short-term basis?

Yes – (specify) _____
 No

B. MANUFACTURED SALES Not Applicable

What products do you manufacture? (Please specify): _____

Do you mix, modify or blend any inject able or ingestible products?

Yes – (specify) _____
 No

(NOTE: if yes, indicate on a separate page the products manufactured and the annual sales volume in units and receipts. Attach brochures on all manufactured products)

Has there ever been a products recall on any products you manufacture or represent?

Yes – (specify) _____
 No

Are any products you manufacture considered by the FDA as an implant able device?

Yes – (specify) _____
 No

C. MANUFACTURERS' REPRESENTATIVES

___ Not Applicable

List all manufacturers for whom you currently act as a Manufacturers' Representative. Indicate if Vendors Coverage is provided by the manufacturer.

Manufacturer	Last Yr Represented	Products	Vendors Coverage?

Have you in the past ten years acted as a Manufacturers' Representative for the following type of equipment:

Therapeutic Equipment?

___ Yes – (specify) _____

___ No

Invasive or implant able devices?

___ Yes – (specify) _____

___ No

FDA Class III devices?

___ Yes – (specify) _____

___ No

D. USED EQUIPMENT REFURBISHMENT/SALES

___ Not Applicable

What used equipment does your firm sell? (please specify) _____

Check all that apply:

___ Diagnostic Radiographic Imaging Systems

___ Magnetic Resonance Imaging Systems

___ Ultrasonic Imaging Systems

___ Therapeutic Radiation systems and/or Therapeutic Radio nuclides

___ EKG/EEG

___ Other: (See supplemental checklist)

Year

Units

Volume \$ Receipts

Current Year (estimate)

1st Prior Year

2nd Prior Year

Are any of the above devices FDA Class III Devices?

___ Yes – (specify) _____

___ No

Are any devices sold as “As Is” or without complete refurbishment to the manufacturer’s current level of safety?

Yes – (specify) _____

No

Attach copies of any warranties issued on used/refurbished equipment.

Do you or have you sold used equipment manufactured by companies other than those you normally represent?

Yes – (specify) _____

No

If **YES**, have your firm received factory training from the original equipment manufacturer (OEM) and do you have complete access to manuals, technical bulletins and factory parts?

Yes

No (comments) _____

E. DISCONTINUED PRODUCTS

Not Applicable

List major types of equipment, supplies or services you have discontinued:

F. INSTALLATIONS

Not Applicable

Specifications for new installations for products (shielding, electrical, plumbing, structural, etc.) are done:

% by your customer % by manufacturer % by you % by your subcontractor

Are complete job records maintained indefinitely including job specifications, change orders and correspondence?

Yes

No (comments) _____

Do you require written customer acceptance and sign off after installation & training?

Yes

No

Do you use Subcontractors? Yes No

If **YES**, indicate Electrical Rigging Mechanical Transport Plumbing
 Maintenance Health Physics Other: _____

Do you require the following from Subcontractors:

Certificates of Insurance? Yes No (**limits must be equal/greater than yours**)

Additional Insured status. Yes No

Do you directly supervise subcontractors? Yes No

If **YES**, do you require:

Favorable Hold Harmless Yes No

Waiver of Subrogation Yes No

G SERVICE Not Applicable

Do you maintain complete service records at your location, including identification and source of all parts? Yes No

What are your basic education training requirements for your technicians?

Comments: _____

How many of your technicians are certified Biomedical Equipment Technicians? (BMET's)? _____

Do you service or have you serviced new or used equipment manufactured by companies other than those you normally represent?

Yes (comment) _____

No

If **YES**, has your firm received factory training from the original equipment manufacturer (OEM) and do you have complete access to manuals, technical bulletins and factory parts?

Yes

No (comments) _____

H. CONTRACTS

Do you require written contracts on all equipment sales, services and installations?

Yes

No (comments) _____

Are there any circumstances under which your firm will contractually agree to accept liabilities or hold other parties harmless?

Yes (attach copies of contracts)

No

PRIOR LIABILITY INSURANCE & CARRIER INFORMATION:

Year	Carrier	Limits	Premium	Claims Made?	Retro Date	Deductible

LOSS HISTORY

Have any General Liability or Product Liability claims been filed against you in the last ten (10) years?

Yes
 No

If **YES**, please list below:

Year	#Claims Open	#Claims Closed	Total Loss

Describe on separate page all individual losses.

Are there any other incidents, conditions, circumstances, defects which may result in claims against your firm?

Yes (comments) _____
 No

** Are you involved in any products made of latex? No Yes, describe: _____

(There will be a latex exclusion attached to the policy)

EXCESS COVERAGE:

Does your firm currently carry excess liability coverage? Yes No

If **YES**, what are your current limits of liability: _____

Is coverage claims made occurrence

If claims made, what is the Retro Date? _____

IMPORTANT: The statements (answers) given above are true and correct. The applicant has not willfully concealed or misrepresented any material fact or circumstance concerning this application.

This application does **NOT** constitute of binder.

Applicants Signature/Title: _____

Date: _____