



MED TECH APPLICATION

Agency Code \_\_\_\_\_ Agency Name \_\_\_\_\_ Date \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insured Name \_\_\_\_\_ Web Address \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Contact Name \_\_\_\_\_ Email Address \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Effective Date \_\_\_\_\_ Expiration Date \_\_\_\_\_  Individual  Joint Venture  LLC  Partnership  Corporation

Location Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Years in Business Under Present Name \_\_\_\_\_

Do you operate out of a retail store that is open to the public?  Yes  No

Do you repair, service, rent or sell any of the following equipment:

- Cardiopulmonary Bypass  Yes  No
Life Support Ventilation  Yes  No
Defibrillators  Yes\*  No
Ventricular Assistance  Yes  No
Pacemakers  Yes  No

\* If you replied yes, please indicate which type of defibrillator

- Manual External Defibrillator  Manual Internal Defibrillator  Automated External Defibrillator (AED)  Implantable Cardioverter Defibrillator
 Wearable Cardiac Defibrillator

Please indicate your certification below:

- Biomedical Imaging Electronics Technician  Certified Radiology Equipment Specialist
 Certified Biomedical Equipment Technician  Certified Electronics Technician - Journeyman-Level - Medical
 Certified Laboratory Equipment Specialist  Certified Laser Repair Technician
 Other

Please explain below:

Empty box for explanation

Has your certification ever been revoked or suspended?  Yes  No

Indicate the estimated receipts and payrolls for the new policy year below:

Medical Equipment:

Sales/Service receipts: \$ \_\_\_\_\_ Service/Repair payroll: \$ \_\_\_\_\_ Rental Receipts: \$ \_\_\_\_\_

- 1. Any sales, service, repair, rental or manufacturing of non-medical equipment?  Yes  No
2. Do you import component parts?  Yes  No
3. Do you export products or have foreign operations?  Yes  No
4. Are any of your products or services subject to registration/regulation/review by any government agency?  Yes  No
5. Do you manufacture, assemble, or package products?  Yes  No
6. Do others manufacture, assemble, package, or install products under your name or label?  Yes  No

7. Do you use subcontractors to repair or service medical devices or machines?  Yes  No
8. Do you subcontract any electrical or plumbing work?  Yes  No
- A. Do you require sub-contractors to provide Certificates of Insurance with general liability limits equal to yours?  Yes  No
- B. Do you require that sub-contractors list you on their general liability policy as an Additional Insured?  Yes  No
- C. Do you require a written contract with all sub-contractors that includes a hold harmless agreement?  Yes  No
13. Do you anticipate any changes in your operation, including the discontinuing of any service or product now offered?  Yes  No
14. Has any insurer ever canceled, restricted or refused to renew your products liability insurance?  Yes  No

THREE YEAR PREMIUM & LOSS HISTORY			
PRIOR CARRIER	POLICY TERM	PRIOR PREMIUM	LOSSES

Explain any losses:

## Commercial General Liability Coverage

General Liability Limits:

General Aggregate	\$2,000,000
Each Occurrence	\$1,000,000
Products & Completed Operations	\$2,000,000
Personal & Advertising Injury	\$1,000,000
Damage to Rented Premises (each occurrence)	\$100,000
Medical Expense (Any one person)	Excluded

### Completion

**NOTICE OF INSURANCE INFORMATION PRACTICES.** In connection with this application for insurance (and subsequent policy renewals), your personal information may be collected from persons other than you and without your authorization (e.g., credit reports). You have the right to review your personal information in our files and may request correction of any inaccuracies contained therein. A more detailed description of your rights and our practices regarding such information will be available upon request and you may contact your agent or broker for instructions regarding how to submit this request to us.

Any person who knowingly files an application for insurance or a statement of claim with materially false information with the intent to defraud an insurance company or another person is committing a fraudulent insurance act. Moreover, any person who has concealed material facts for the purpose of providing misleading information is also committing a fraudulent insurance act. These acts are crimes and subjects the person to criminal and [NY: substantial] civil penalties. (Not applicable in CO, FL, HI, MA, NE, OH, OR, or VT; in DC, LA, ME, TN, VA and WA insurance benefits may also be denied). In Florida, it is a third degree felony to knowingly file a statement of claim or any application containing false, incomplete, or misleading information with the intent to injure, defraud and/or deceive any insurer.

The undersigned is an authorized representative of the applicant and acknowledges that reasonable inquiry has been made to obtain the information on this application. He/she acknowledges that the answers are true, correct and complete to the best of his/her knowledge.

\_\_\_\_\_  
**Producer's Signature**

\_\_\_\_\_  
**Producer's Name (Please Print)**

\_\_\_\_\_  
**Applicant's Signature**

\_\_\_\_\_  
**Date**