

Check the professional categories below that are applicable to your operation and provide head count, billed hours and receipts for each:

Profession	Full Time Equivalent (40 Hr. Week)		Billed Hours		% of Receipts
	Employed (W-2)	Contracted (1099)	Employed (W-2)	Contracted (1099)	
Admin/Clerical					
Home Health Aide					
LPN/LVN					
Nurse Aide					
CNA					
Registered Nurse					
Occupational/Speech Therapist					
Social Worker					
Physical Therapist					
Resp. Therapist					
Rehab Therapist					

NOTE: MD's, DD's, DDS's, Paramedics, PA's, EMT's, Nurse Midwives and Nurse Anesthesiologists are not eligible for coverage.

List states of operation: _____

If multiple states, please complete Multi-state Supplemental at end of application

Are there any medical doctors on the premises? YES NO

If YES – are they operating in an administrative capacity? YES NO

If NO – Please describe their duties:

Applicant's Affidavit and Signature: I hereby represent that the aforementioned statements and answers are correct and complete. I further understand that my answers and statements will be the basis for determining my insurability and premium for the applied coverage. I further understand that the completion and signing of this application does not bind the applicant or the company to complete the insurance and supplemental information may be requested to produce a binding quote.

Signature: _____

Date: _____

Please return your completed application to:

The Solutions Group
 2211 NW Military Hwy., Suite 211
 San Antonio, TX 78213
 Ph: 800-866-2682
 FAX: 866-811-4132
 Alternate FAX: 210-568-4904





DURABLE MEDICAL EQUIPMENT SUPPLEMENT

Will you provide any durable medical equipment?
(If yes, complete this page)

Yes No

If yes, Sale Only Rental Sales & Rental

Receipts broken down by category:

Category I: **EXPENDABLE ITEMS** – Intended for one time usage and disposed (i.e., adhesive tape, bandages, or hypodermic needles, etc.)

a. Annual Sales: \$ _____

Category II: **NON-EXPENDABLE ITEMS** – Excluding diagnostic or treatment equipment or devices. This category includes, but is not limited to, hospital beds, bathroom safety bars, portable toilets, patient lifts or hoists, traction apparatus, ambulatory aids such as walkers, strollers, canes, crutches, wheelchairs, etc, and prosthetic devices and IV stands, including medical and surgical instruments unless considered diagnostic or treatment, etc.

b. Annual Sales: \$ _____

c. Annual Lease / Rental Receipts: \$ _____

Category III: **DIAGNOSTIC OR TREATMENT DEVICES** – This category includes oxygen and other medical gases used in conjunction with respiratory therapy (excluding ventilators), treatment devices or equipment NOT used to sustain life or perform critical life monitoring functions. Also included are blood pressure gauges, IV pumps, portable EKG machines, or sending devices.

d. Annual Sales: \$ _____

e. Annual Lease / Rental Receipts: \$ _____

Do you distribute oxygen tanks?

Yes No

If yes, are they:

Pre-Filled Self-Filled

If yes, does storage meet NFDA standards?

Yes No

Category IV: **LIFE SUSTAINING OR CRITICAL LIFE MONITORING EQUIPMENT OR DEVICES** – This category includes dialysis or heart/lung machines, apnea monitors, SIDS monitors or any other life dependent monitors or any other equipment or devices that malfunction/failure or improper function of which could result in death or serious deterioration in health condition.

f. Annual Sales: \$ _____

g. Annual Lease / Rental Receipts: \$ _____

Category V: **DURABLE MEDICAL EQUIPMENT** – Does the account sell or rent any of the following types of durable medical equipment? (If yes, please check type below)

Surgical Implant Devices

Anesthesia Equipment

Radiology Equipment

Laboratory Equipment

Blood Cleansing Equipment

Laser Equipment

h. Annual Sales: \$ _____

i. Annual Lease / Rental Receipts: \$ _____

TOTAL ANNUAL RECEIPTS OF MEDICAL SUPPLIES AND / OR EQUIPMENT (ADD A – I) \$ _____

Does applicant rent, lease, repair or do maintenance on any medical or therapeutic supplies or equipment?

Yes No

If yes, total annual rental receipts of such medical supplies and or equipment:

\$ _____

List type of equipment rented or attached schedule:

Are service records kept on rentals?

Yes No



MULTI-STATE SUPPLEMENTAL

Location Addresses:

	Street	City	County	ST	ZIP
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____
6.	_____	_____	_____	_____	_____
7.	_____	_____	_____	_____	_____
8.	_____	_____	_____	_____	_____
9.	_____	_____	_____	_____	_____
10.	_____	_____	_____	_____	_____

Combined Revenue By State:

State: _____	Gross Receipts Last 12 Months: _____	Gross Receipts Next 12 Months: _____
State: _____	Gross Receipts Last 12 Months: _____	Gross Receipts Next 12 Months: _____
State: _____	Gross Receipts Last 12 Months: _____	Gross Receipts Next 12 Months: _____
State: _____	Gross Receipts Last 12 Months: _____	Gross Receipts Next 12 Months: _____
State: _____	Gross Receipts Last 12 Months: _____	Gross Receipts Next 12 Months: _____



WORKERS COMPENSATION

Workers Compensation coverage is based on a percentage of your payroll.

To get coverage for the first year of business, we need an estimate of what you plan to pay your employees over the next 12 months. If you're unsure, we can give a quote based on \$30,000 to \$50,000 worth of payroll to get your started.

# of Full Time		# of Part Time		Annual Payroll by Class	Classification or Description
W-2	1099	W-2	1099		
					Certified Caregivers (CNA, LVN, RN)
					Non-Certified Caregivers (Comp. Care Aide)
					Clerical
					Outside Sales
					Other

Total Number of Employees: _____

Total Payroll: \$_____

FEIN: _____

Ownership Information:

Name	DOB	% Ownership	Corporate Title