



Aon O & P Insurance Program Business Insurance Quote Form

GENERAL INFORMATION

- 1. Name of Corporation: _____
- 2. Mailing Address: _____

- 3. Phone: (_____) _____ Fax: (_____) _____
E-mail: _____ Website Address: _____
- 4. Applicant is: Individual Partnership Corporation Other _____

Brief description of your operations: _____

Any other operations other than Orthotics & Prosthetics: Yes No
If yes, please explain: _____

FEIN _____ State FEIN issued in: _____ State of Incorporation: _____ Years in business: _____
Effective Date Needed: _____

PROPERTY COVERAGE

(Includes business owned buildings and contents)

Includes locations of all premises owned, or leased if a tenant (use separate sheet for additional locations)

BLDG AGE*
If over 20 yrs-
see back page

PROPERTY LOCATION	SQ. FT	OWN/TEN	CONST.	BLDG. LIMIT, if owned	CONTENTS* LIMIT	BLDG AGE*

*CONTENTS INCLUDE INVENTORY STOCK, MACHINERY, EQUIPMENT, COMPUTERS, PROPERTY OF OTHERS, TENANTS IMPROVEMENTS, AND BETTERMENTS.

MORTGAGEE/LOSS PAYEE: _____

LOCATION SAFETY

- 1. Are all steps covered with anti-slip surfaces? Yes No
- 2. Are handrails provided on all stairways? Yes No
- 3. Are parking lots and sidewalk surfaces free of debris and smooth? Yes No
- 4. Is there adequate exterior lighting? Yes No
- 5. Are edges of curbs, sidewalks and steps color coded to identify raised surfaces? Yes No
- 6. Who is responsible for the upkeep of the building, such as snow/ice removal, patching parking lot?

BUSINESS INCOME COVERAGE

You automatically receive \$500,000 of Business Income Coverage at each location. If you need additional amounts, please complete the business income formula for optional quotation.

Start with sales	\$	_____
Subtract cost of goods sold	-\$	_____
Add adjustment for growth	+\$	_____
Add specialties (rent, payroll, loans)	+\$	_____
Subtract Automatic Coverage	-\$	500,000
Total Proposed Limit	=\$	_____

LIABILITY COVERAGE
(Includes product, professional and premises liability)

Limit of liability: _____ \$1,000,000 Each Occurrence/\$2,000,000 Annual Aggregate
 _____ \$1,000,000 Each Occurrence/\$3,000,000 Annual Aggregate

PREMIUM BASE DESCRIPTION	ESTIMATED ANNUAL NET* SALES
Patient Care: Includes all sales for items you make, fit and/or alter for individual patients.	\$
Supplier/Distributor: Includes all items purchased from others that you resell to another facility or distributor.	\$
Supplier/Manufacturing: No patient contract. Includes items manufactured by you and sold to facilities (i.e. central fabrication).	\$
Soft Goods and Accessories: Includes items sold directly to patient with no altering or re-labeling of parts. Includes but not limited to, crutch tips, stump socks, shoes, etc.	\$
DME (Durable Medical Equipment): Items sold to the public that include but not limited to, wheelchairs, TENs units, lifts, bathroom accessories, oxygen, etc.	\$

(*ANNUAL NET SALES IS YOUR SALES AFTER DEDUCTING "DISALLOWED" OR UNCOLLECTIBLE SALES. THIS DOES NOT REPRESENT NET PROFIT.
THIS POLICY IS NOT AUDITABLE. SO PLEASE BE ACCURATE WITH YOUR SALES)

STAFF INFORMATION

Job Title	# of Employees
Practitioners	
Assistant	
Fitter	
Technician	
Physical Therapists	

UMBRELLA LIABILITY COVERAGE
(Catastrophe Coverage)

Limit Desired: \$1,000,000 \$2,000,000 \$5,000,000 Other _____

All of the following questions must be answered and the minimum underlying limit requirements met:
 Business Auto \$1,000,000 CSL; Employers Liability 500/500/500 (subject to company approval)

- Workers Compensation carrier: _____
- Workers Compensation Policy Number: _____ Period: _____
- Automobile carrier: _____ Automobile Policy # _____
 Eff./Exp. Dates: _____ # of Vehicles: _____ Premium: _____
- Do you: Own any Water Craft? Yes No; Own any Air Craft? Yes No; Lease any Air Craft? Yes No

OTHER OPTIONAL COVERAGE/POLICY
(Check any that you are interested in)

- | | |
|--|---|
| <input type="checkbox"/> Workers Compensation Policy | <input type="checkbox"/> Employment Related Practices |
| <input type="checkbox"/> Business/Automobile Policy | <input type="checkbox"/> Directors & Officers |
| <input type="checkbox"/> ERISA Bond | <input type="checkbox"/> Flood/Wind (if coastal exposure) |
| <input type="checkbox"/> Medicaid Bond | <input type="checkbox"/> Other _____ |

GENERAL INFORMATION - PART 2

- Are you a member of an Orthotic & Prosthetic Association? Yes No
 Association Name: _____
- If your building is over 20 yrs old, please provide the year of the following updates:**
Heating/A/C: _____ **Plumbing:** _____ **Electrical:** _____ **Roof:** _____
- Is your firm accredited or certified by: ABC/BOC State Agency other (specify) _____
- Do you sell, rent, repair, or install (IF NONE, INDICATE 0%): Heart Monitoring Devices _____%, Van Lifts _____%,
 Diagnostic Equipment _____%, Oxygen _____%, Electrical Equipment _____%, Automobile Hand Controls _____%,
 Stair/Van Lifts _____%, Wheelchairs _____%, TENS _____%, Traction Devices _____%, Surgical Equipment _____%,
 Ramps _____%, Non-Invasive Halos/Cranial Devices: _____%, Invasive Halo/Cranial Devices: _____%
- Do you distribute any foreign products in the US? Yes No If yes, sales \$ _____
- Are any of your products sold or distributed overseas? Yes No If yes, sales \$ _____

PRIOR HISTORY

Have you had any losses/claims in the past 3 years? Yes No If yes, please complete the following:

Description of Loss	Date of Loss	Amount Paid

Current Insurance Carrier: _____ Years with Current Carrier: _____

Expiration Date: _____ Premium: _____

AOPA Workers Compensation Questionnaire

Thank you for inquiring about the Aon Workers' Compensation Insurance Program. This program provides statutory coverage in all but a few states. To obtain your personal quotation, please answer the following questions and supply the requested information.

PLEASE PRINT

COMPANY NAME (Include DBA's): _____

Individual Partnership Corporation Other

FEDERAL ID #: _____

COMPANY ADDRESS: _____

TELEPHONE: (_____) _____ FAX: (_____) _____

E-MAIL: _____

ANNUAL SHOP/LAB
PAYROLLS

ANNUAL CLERICAL
PAYROLLS

ANNUAL RETAIL/SALES
PAYROLLS

\$ _____

\$ _____

\$ _____

Please list the names of your **Officers**, their titles, their payrolls, their job description, and whether they should be excluded from coverage. (Use additional sheet if necessary)

Name: _____ Title: _____ Annual Payroll: \$ _____

Job Description: _____ Exclude: Yes No

Name: _____ Title: _____ Annual Payroll: \$ _____

Job Description: _____ Exclude: Yes No

PREVIOUS CARRIER: _____

PREMIUM MODIFICATION (If any): _____

EXPIRATION DATE: _____

PREMIUM: \$ _____

HAS COVERAGE EVER BEEN CANCELED OR DECLINED? YES _____ NO _____

ANY LOSSES FOR THE PAST THREE YEARS? (If yes please attach loss runs) YES _____ NO _____

COMMENTS: _____

Return to:

Affinity Insurance Services
 159 E. County Line Road • Hatboro, PA 19040-1218 • (800) 544-2672 • (847) 953-4779 Fax