



VGM INSURANCE

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PRODUCT LIABILITY APPLICATION FOR MEDICAL PRODUCTS DISTRIBUTORS

Applicant Instructions: Application must be signed by owner, partner or officer. This application shall be attached to and become part of any insurance policy issued.

APPLICANT

A. Full name of all entities to be insured: _____

B. Principal address: _____

C. Phone#: _____ Fax#: _____

D. Individual Partnership Joint Venture Limited Partnership Other

E. Years in business under present name: _____

F. Describe present or prior affiliation with other firms: _____

G. Proposed effective date for this insurance: _____

FEIN: _____ Website: _____

CONTACT NAME: _____

PRODUCTS

A. List all products you distribute. For each product, list whether you are (I) Importer, (W) Wholesaler, (MR) Manufacturers Representative, (D) Distributor. List who you sell to: (W) Wholesaler, (MR) Manufacturers Representative, (R) Retailer, (C) Direct to Customer.

Product	Gross Sales (Est. This Yr.)	You Are	You Sell To
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

B. Gross Sales: Last Year _____ Preceding Year _____

C. Have you discontinued or are you considering discontinuing any product to be covered by this insurance? Yes No

If Yes, please describe fully: _____

D. With respect to each product

- 1. Do you manufacture completed products? 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 subject to regulation by any government agency? Yes No

Explain any "yes" answer to 2, 3 or 4 above: _____

- E. Do you service, maintain or repair any products? Yes No

If yes, please explain and attach copies of contracts if applicable: _____

- F. Do you obtain hold harmless or indemnity agreements from dealers, suppliers or manufacturers? Yes No

Please attach copies

- G. Do you require certificates evidencing Products Liability Insurance from dealers, suppliers or manufacturers? Yes No

Please attach copies

PROCESSING AND QUALITY CONTROL

- A. Do others manufacture, assemble, package or install products under your name or label? Yes No

- B. Do you manufacture, assemble, package or install products for others under their name or label? Yes No

Please explain any "yes" answer to A.1 or 2 above: _____

CLAIMS HISTORY (attach company loss runs)

- A. Please list all claims during the past five (5) years:

Policy Period	Total Amounts Paid	Total Amounts Reserved
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

- B. Describe, in detail, any claim in excess of \$10,000: _____

- C. Are you aware of any circumstance, which may result in a claim or suit being brought or made against the applicant or any of your employees? Yes No

If yes, please describe: _____

INSURANCE

A. Please indicate prior insurance carried:

Year	Company	Deductible/SIR	Limit Carried	Premium
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

B. Is your current coverage Claims Made or Occurrence

If you have ever carried a "Claims Made" policy please provide Retro Date: _____

C. Insurance requested:

1. Limit of Liability: _____

2. Deductible/SIR: _____

D. Has an insurer ever canceled or refused to renew your Products Liability Insurance? Yes No

If yes, please explain: _____

Please attach Brochures, Labels, Service Agreements etc.

Any person who knowingly 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 also punishable by civil penalties in certain jurisdictions.

The Warranties following will be made a part of any policy issued under this program.

WARRANTED: The Company named on the front hereof and as named below will adhere to the following quality criteria to be eligible for (and remain eligible for) coverage under this insurance program:

- A. Distributor makes no intentional physical or chemical change in the products distributed
- B. Distributor does no repackaging, except for the purpose of inspection, demonstration, testing or the substitution of parts under instruction from the manufacturer, and afterwards product is repackaged in the original container.
- C. Distributor does no assembly or repair of products.
- D. Distributor is distributing products only for manufacturers who present proof of insurance with insurers licensed in the United States and whose products liability insurance is endorsed with an Additional Insured-Vendors endorsement (Commonly called Broad Form Vendor's Endorsement) with the wording of the Insurance Services Office (ISO) or substantially similar in wording to ISO, which includes the distributor as an additional insured.
- E. The distributor provides no express or implied warranties of mercantability, fitness for use, or safety other than those warranties distributor is expressly authorized to provide as an agent on behalf of the manufacturer, by the manufacturer.

WARNING!! This is an important document, which could affect your legal rights. Please **read it carefully** and **be certain it is correct and complete.** Your signature below is your warranty to us that we can rely on this form. We have made no investigation of our own and the coverage decision will be based on this information. **COVERAGE IS NOT BOUND OR STARTED BY THIS FORM. WE MAKE NO PROMISE TO INSURE. THIS IS ONLY A REQUEST FOR A QUOTE. YOU ARE NOT COVERED UNTIL AND UNLESS YOU RECEIVE A BINDER SO STATING.**

The coverages that we are quoting from information on this form are Product/Completed Operations & Professional and/or General Liability Insurance. **If you have any questions about the form or your answers please ask before completing the form.**

The questions in this application are not intended to, nor do they, indicate the existence, non-existence or limitations on any items of coverage. This document does not in any fashion determine the coverage provided.

Signature and Attestation: Name (Print): _____

Return To: Signature: _____

VGM Insurance Title: _____

A Division of DME Association, Inc. Date: ____/____/____