

**MEDICAL EQUIPMENT INSURANCE APPLICATION**



**Page One - To be completed by applicant**

Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

Telephone: \_\_\_\_\_

Email: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
\_\_\_\_\_

Website: \_\_\_\_\_

Desired Effective Date of Insurance: \_\_\_\_\_ Term (1, 2 or 3 years): \_\_\_\_\_

Address of location of equipment, and description of facility:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is facility in a Tier One or Two Coastal County: \_\_\_\_\_

Years of Operation: \_\_\_\_\_ Annual Gross Revenue: \_\_\_\_\_

If other than an accredited hospital, provide COPE (Construction, Occupancy, Protection, Exposure):  
\_\_\_\_\_  
\_\_\_\_\_

Schedule of Equipment to be Insured: Complete second page

Loss Experience:	# of Claims	Total Amount of Losses	Causes of Loss
Last 12 months:	_____	_____	_____
Previous 12 Mos.:	_____	_____	_____
Next Previous 12 Mos.:	_____	_____	_____
Next Previous 12 Mos.:	_____	_____	_____
Next Previous 12 Mos.:	_____	_____	_____

Previous Insurer: \_\_\_\_\_

I hereby certify that this application and its attachments are a good faith representation of the information requested.

\_\_\_\_\_  
(Name / Title)

