

TO: Our Agents

RE: **Update on DMEPOS Medicare Bond!**

The \$50,000 Federal Medicare bond requirement for Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) continues to generate tremendous interest; and we're pleased to provide a streamlined application process!

Application Checklist

- Step 1 — All applicants complete all blanks on Page 1 of the Form 10-E-DMEPOS Application, including the applicant's NSC/PTAN and NPI numbers.
- Step 2 — Provide business and personal indemnity in Section 3 of page 2.
- Step 3 — Attach business and personal financial statements if needed as follows:
 - Does applicant have a license issued by a state board to operate as: pharmacy (to dispense prescription drugs), optician, hospital/clinic/skilled care facility?
 - If yes, does applicant need bonding for more than three (3) locations or NPI numbers?
 - If more than three (3) locations or NPI numbers - please provide business and personal financial statements and skip Step 4.
 - If three (3) or less locations or NPI numbers - skip Steps 3 and 4. There is no need to provide financial statements.
 - All other applicants - please provide business and personal financial statements and complete Step 4.
- Step 4 — Complete all blanks in Section 2 on page 2. **

** Applicants for three locations or less licensed to operate as: pharmacy (to dispense prescription drugs), optician; hospitals/clinics/skilled care facilities, **may skip Steps 3 and 4.**

Medicare: DMEPOS Bond Rate

Suppliers/Providers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies for each location with a NPI (National Provider Identification) number requiring a bond \$5 per \$1,000

We are pleased to offer our streamlined application process and competitive rates. For quicker service, apply online by using bONDLINE. Just point, click, and print! If you have any questions about this bond requirement, please send us an e-mail at uwservices@cnasurety.com or call us at 1-800-331-6053. We write more bonds than any other company in the industry and **WE WANT YOUR BUSINESS!**

CNA Surety
Underwriting Services
1-800-331-6053
www.cnasurety.com



www.cnasurety.com

Form 10-E-DMEPOS

- Individual
- Partnership
- Corporation
- Limited Liability Company
- Limited Liability Partnership

**EASY APPLICATION FOR MEDICARE PROGRAM:
SURETY BOND FOR SUPPLIERS OF DURABLE MEDICAL EQUIPMENT,
PROSTHETICS, ORTHOTICS AND SUPPLIES**

ALL APPLICANTS — COMPLETE PAGE 1 AND APPLICABLE SECTIONS ON PAGE 2

PLEASE PRINT OR TYPE. (See Back for Instructions)

Applicant(s) - Individual, partners, or corporate owner(s). List the principal owner first. Attach additional Form 10-E's and cross reference if more than three owners. **EACH MUST SIGN ON BACK.**

1. Name _____
Residence Address _____

Telephone # _____ Single
Social Security No. _____ Married (spouse must sign on back.)
Percent of Business Ownership _____

2. Name _____
Residence Address _____

Telephone # _____ Single
Social Security No. _____ Married (spouse must sign on back.)
Percent of Business Ownership _____

3. Name _____
Residence Address _____

Telephone # _____ Single
Social Security No. _____ Married (spouse must sign on back.)
Percent of Business Ownership _____

Business or Corporate Name: _____

Business Address _____

Telephone # _____
TIN _____
NSC/PTAN _____
NPI No. _____

Number of Years in this Business:	Number of Years Licensed:
Type of Bond Requested:	
Amount of Bond: \$	Effective date:

Has the business, or any owner/applicant:

a. Ever been convicted of a crime? Yes No

b. Ever had their license suspended, revoked or denied? Yes No

c. Ever been party to a surety bond claim? Yes No

(If any answers are yes, provide details.)

Agent's recommendation/additional comments:

Please answer the following for EACH location under common ownership needing a bond (attach Form 10-E Supplemental for 2nd or more locations). Complete a new Application for every location under different ownership.

Location Name and Address _____
Does applicant have a License issued by a State Board to dispense/operate as: prescription drugs; optician;
 Hospital/Clinic/Skilled Care Facility License Number _____ Issuing State _____
Type _____ Date _____
Total Annual Sales _____
Percent of sales from Durable Medical Equipment, Prosthetics, Orthotics and Supplies _____

AGENCY DATA
Agency Name _____ Agency Code _____

Any person who knowingly and with intent to defraud any insurance company or person files an application 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 under applicable law. The applicants and indemnitors certify the truth of all statements in the application and authorize the Company to verify this information and to obtain additional information from any source including obtaining a credit report.

CNA Surety P.O. Box 5077 Sioux Falls, SD 57117-5077 1-800-331-6053 / Fax 605-335-0357

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Instructions

- ✓ Applicants needing 3 or less bond(s) and are licensed by a State Board to dispense/operate as prescription drugs, optician, hospital/clinic/skilled care facility - Skip Sections 1 and 2 but Complete Section 3; If more than 3 bonds - Complete Section 1 (skip 2) and complete 3.
- ✓ All other Applicants - Complete Section 1, Section 2, and Section 3.

Section 1 — FINANCIAL STATEMENT as of _____

Attach Business and Personal Financial Statements prepared by an Accountant or comparable Financial Statements.

☐ Check if prepared Financial Statements are attached separately, OR complete the Financial Statement on Supplemental Form 10-E DMEPOS.

Section 2 — Applicants not licensed to dispense/operate as: pharmacy (to dispense prescription drugs), optician, hospital/clinic/skilled care facility, please complete the following:

Type of business _____

What kind of equipment and supplies _____

Customized or Off-the-shelf _____

Who are primary customers _____

Percent of business transacted through: storefront _____, home visits _____, mail order _____, internet _____, other (describe) _____

Number of Employees _____ Number of Employees handling Medicare _____

Explain Medicare billing process and knowledge _____

Section 3 — INDEMNITY — All Applicants regardless of how licensed must have a completed and signed indemnity form on file with CNA Surety.

ALL Applicants, Owners, and Indemnitors must sign below.

The undersigned applicant and indemnitors hereby request Western Surety Company, Universal Surety of America, Surety Bonding Company of America and any affiliated company, their successors or assigns (with such company/companies referred to herein as the "Company") to become their surety. The undersigned hereby certify the truth of all statements in the application, authorize the Company to verify this information at the time of application and as needed, on an ongoing basis and to obtain additional information from any source, including obtaining credit reports at the time of application, in any review or renewal, at the time of any potential or actual claim, or for any other legitimate purposes as determined by the Company in its reasonable discretion, and jointly and severally agree:

- (1) To pay premiums, including renewal premiums and any other charges, to the Company or its agents, when due,
- (2) To completely INDEMNIFY the Company from and against any liability, loss, cost, attorneys' fees and expenses whatsoever which the Company shall at any time sustain as surety or by reason of having been surety on this bond or any other bond issued for any applicant and or indemnitor, or for the enforcement of this agreement, or in obtaining a release or evidence of termination under such bonds, regardless of whether such liability, loss, costs, damages, attorneys' fees and expenses are caused, or alleged to be caused, by the negligence of the Company,
- (3) To furnish the Company with satisfactory and conclusive termination evidence that there is no further liability on this bond or any other bond issued for applicant,
- (4) Upon demand by the Company for any reason whatsoever, to deposit current funds with the Company in an amount sufficient to satisfy any claim against the Company by reason of such suretyship,
- (5) That the Company shall have the right to handle or settle any claim or suit in good faith and the Company's decision shall be binding and conclusive on the undersigned. An itemized statement of loss and expense incurred by the Company, shall be prima facie evidence of the fact and extent of the liability of the undersigned to the Company,
- (6) That the Company may decline to become surety on any bond and may cancel or amend any bond without cause and without any liability which might arise therefrom,
- (7) That the Company shall, without notice, have the right to alter the penalty, terms and conditions of any bond issued for undersigned, and this agreement shall apply to any such altered bond. The liability for the undersigned shall not be affected by the failure of the undersigned to sign any bond, nor any claim that other indemnity or security was obtained, nor by the release of any indemnity, nor the return or exchange of any collateral obtained and if any party signing this agreement is not bound for any reason, this agreement will still be binding on each and every other party
- (8) That if a contract or performance bond is issued hereunder, the undersigned hereby assign to the Company any monies now due or hereafter becoming due under the contract, including all deferred payments and retained percentage, supplies, tools, plants, equipment and materials due or used on the contract,
- (9) At the Company's discretion, this indemnity agreement shall be governed in all respects by the laws of the State of South Dakota and the undersigned applicant and indemnitors consent to the jurisdiction of the courts of the State of South Dakota and the United States District Court for the District of South Dakota in all actions or proceedings arising from or relating to this indemnity agreement,
- (10) That this indemnity may be terminated by the undersigned, or any one or more parties so designated, upon written notice sent registered mail to the office of the Company at Sioux Falls, South Dakota 57104, of not less than twenty (20) days. In no event, shall any termination notice operate to modify, bar, discharge, limit, affect or impair the liability of any party hereto, for any bonds, undertakings and obligations executed prior to the date of the Company's receipt and notice of such termination
- (11) In the event of any payment by the Company, to pay the Company interest on such amounts at the highest legal rate from the date such payments are made.

Signed this _____ day of _____, _____

Signature & Business/Corporate Title

"Indemnitor"

"Indemnitor"

"Indemnitor"

NOTE: Personal indemnitors should sign their names before the word "indemnitor".