IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 of the Illinois Compiled Statutes. Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed. This form has been approved by the Forms Management Center.

CERTIFICATION OF INSURANCE

SUPPORTING DOCUMENT

HME-INS

APPLICANT: ***Complete the applicant section of this form, then have your authorized insurance agent complete the remainder of the form. The completed form must be submitted WITH your application for licensure. This is the only form which you need to submit if you are certifying to current insurance coverage after the expiration of a previously held policy.***

1. NAME OF INSURED HOME MEDICAL EQUIPMENT & SERVICES PROVIDER BUSINESS (Must be exactly as it appears on application, renewal form or license.)

2. FEIN (If applicable)

3. SOCIAL SECURITY NUMBER (If individual owner)

__ __ __ - __ __ - __ __ __ __

4. ADDRESS STREET, CITY, STATE, ZIP CODE (Specific Address of insured's location covered by insurance policy.)

5. NEW APPLICANTS ONLY

REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application.

Home Medical Equipment & Services Provider — Profession Name

2 0 3 — Profession Code

6. TELEPHONE NUMBER (Where you can be reached during the day)

Area Code (__ __ __) __ __ __ - __ __ __ __

7. RENEWAL APPLICANTS AND PERSONS VERIFYING CURRENT INSURANCE ONLY.

INDIVIDUAL LICENSE NUMBER - RECORD THE LICENSE NUMBER YOU HOLD (IF APPLICABLE).

203 - _____

I hold commercial general liability insurance in at least the minimum amount of $1,000,000 including, but not limited to coverage for product liability and professional liability. Under penalties of perjury, I declare that I have examined this form, and to the best of my knowledge, it is true, correct, and complete.

Type or Print Name of Owner or Person Designated to Sign for Firm

Signature of Owner or Person Designated to Sign for Firm

Type or Print Title of Owner or Person Designated to Sign for Firm

Date

INSURANCE COMPANY: Complete the following information and return this form to the insured party.

A. NAME OF INSURANCE COMPANY

B. NAME OF AUTHORIZED AGENCY

C. INSURANCE COMPANY HOME ADDRESS: STREET, CITY, STATE, ZIP CODE

D. AGENT'S ADDRESS: STREET, CITY, STATE, ZIP CODE

E. INSURED'S POLICY NUMBER

F. AGENT'S BUSINESS TELEPHONE NUMBER

Area Code (__ __ __) __ __ __ - __ __ __ __

G. EFFECTIVE DATE OF POLICY

__ __ / __ __ / __ __
Month Day Year

H. EXPIRATION DATE OF POLICY

__ __ / __ __ / __ __
Month Day Year

If this Policy is terminated prior to its expiration, the Company agrees to give written notice to the Department of Financial and Professional Regulation, Division of Professional Regulation, at least thirty (30) days prior to the effective date of cancellation.

Signature of Authorized Agent

Date