

DENTURIST OFFICE - BUSINESS OWNERS' POLICY - APPLICATION

DATE: _____

NAMED INSURED: _____

MAILING ADDRESS: _____

CITY: _____ COUNTY: _____ ST: _____ ZIP: _____

LEGAL ENTITY: Individual Partnership Corporation FEIN: _____

EFFECTIVE DATE OF COVERAGE: _____

CONTACT NAME: _____ CONTACT TITLE: _____

CONTACT PHONE: _____ CONTACT FAX: _____

Please advise of Association Membership: Yes No - Association Name: _____

GENERAL LIABILITY LIMIT

\$2,000,000 Occurrence / \$4,000,000 Aggregate

EXCESS LIABILITY LIMITS

Commercial Umbrella: _____

PROPERTY DEDUCTIBLE (Select One)

\$250 \$500 \$1,000 \$2,500

(Limit)

HIRED / NON-OWNED AUTO LIABILITY Yes No

If Yes - Is there a Commercial Auto Policy in Force? Yes No

If Yes - Are non-owned vehicle liability limits a minimum of \$100,000? Yes No

COASTAL PROPERTY

Is Risk less _____ miles from coast

LOCATION ADDRESS

Street: _____

City: _____ County: _____

State: _____ Zip: _____

LIMITS OF INSURANCE - STANDARD

Building: \$

Business Personal Property: \$

Business Computer: \$10,000

Accounts Receivable: \$25,000

Employee Dishonesty: \$10,000

Business Income: 12 Month no Dollar Limitation, Payroll, Extra Expense & Loss of Income Included

Energy Equipment: Yes No

Employee Benefit Liability: Yes No

Water Damage: \$25,000 (Sewer & Drain Backup)

Valuable Papers: \$15,000

RATING INFORMATION

Construction of Building: Frame Joisted Masonry Masonry Non-Combustible Fire Resistive

Sprinklered: Yes No Local Alarm: Yes No Central Station Alarm: Yes No

Year Bldg Built _____ If over 25 years old, Updates – Roof: _____ Plumbing: _____ Electrical: _____

Total Area of Building: _____ Area of Vacant Space in Building: _____

Area Leased by Insured: _____ Area Insured Leases to other occupants: _____

Number of Stories: _____ Number of Elevators: _____ Occupancy Type: Retail Office Residential

UNDERWRITING INFORMATION

Years in Business: _____ Hours of Operation: _____ # of Employees: _____ Annual Sales: \$ _____

Any products sold direct to the public: Yes No

Current Insurance Carrier: _____ Current Annual Premium: _____

LOSS INFORMATION

DATE OF LOSS	DESCRIPTION OF LOSS	AMOUNT PAID