

BUSINESS OWNERS POLICY (BOP) APPLICATION

Your Name _____ Date _____

Company Name _____

Address _____

City _____ State (or Province) _____ Country _____ ZIP _____

Phone Number () _____ Fax Number () _____ Email _____

Date new coverage needs to be effective ____ / ____ / ____ For internal use only. Email address will never be sold or shared.

DESCRIBE YOUR BUSINESS

Legal Entity Corporation Limited Liability Company Partnership Individual Other _____

Please provide a complete description of your business _____

Annual Sales/Receipts \$ _____ Year Business Purchased/Began _____ Federal Employer ID Number _____ (If applicable)

Are there any other businesses that are owned or operated by you that are not to be covered by this policy? Yes No If Yes, please describe on separate page.

Number of employees _____ Full-time: _____ Part-time: _____

PROPERTY AND COVERAGE INFORMATION

Please tell us about each of your locations.

(Copy this section and complete for each additional location, use as many pages as needed.)

How many stories? _____ Location Number: _____ of _____

Location Address: Same as the company address: Yes No

If No, please enter the building address:

Street: _____

City: _____ County: _____ State: _____ Zip: _____

Square Feet Occupied: _____ sq. ft. What year was the building built? _____

If older than 20 years, please enter the year any updates were made to the building:

Re-wired _____ Re-roofed _____ Re-plumbed _____ HVAC _____

Approx. total building sq. ft.: _____

Are there other businesses in the same building? Yes No

If Yes, please provide a complete description of the other businesses.

Please check the type of building construction (check only one): Frame

Joisted Masonry Non-Combustible Masonry Non-Combustible Fire Resistive

Is your building 100% sprinklered? Yes No

COVERAGE REQUESTED

General Liability Limits: 1M/2M 2M/4M

For this building, are you the: Owner Tenant

Deductible: (check only one) \$500 \$1,000 \$2,500 \$5,000

Building Replacement Cost at 100%: (if owned) \$ _____

Tenant's Improvements and Betterment: \$ _____

Business Contents:

(Indicate the cost to replace with new equipment in the event of a total loss)

Radiograph Equipment: \$ _____

Orthodontia Operatories: (furniture, equipment, instruments) \$ _____

Number Of Chairs: _____

All Other Orthodontia Equipment: \$ _____

Laboratory Equipment: \$ _____

Office/Waiting Room Furniture: \$ _____

Anesthesia Related Equipment: \$ _____

Other (please describe): _____ \$ _____

TOTAL BUSINESS CONTENTS: \$ _____

ADDITIONAL INTERESTS (MORTGAGE, LOSS, PAYEE, ADDITIONAL INSURED)

Name: _____

Address: _____

Relationship With Insured: _____

Please fax completed application to 866.817.9009 or mail to: 1200 E. Glen Ave., Peoria Heights, IL 61616
If you have any questions, please call 800.622.0344.

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UMBRELLA LIABILITY

This coverage provides your firm additional liability protection.

Please choose one coverage amount: \$1M \$2M Greater than \$2M Do not quote umbrella

Desired Effective Date: ___ / ___ / ___

EMPLOYMENT RETIREMENT INCOME SECURITY ACT (ERISA)

Do you have a retirement plan for your employees? Yes No

Welfare & Retirement Fund Coverage (ERISA): \$ _____ Bond limit (limit equal to 10% of fund balance)

Official Name Of Retirement Plan: _____

Desired Effective Date: ___ / ___ / ___

COMMERCIAL AUTO

Does the insured have a commercial auto policy in force? Yes No What is the maximum radius of operation?

If **No**, do any employees use their personal autos or hired/rental vehicles for part of their job responsibilities? Yes No

If **Yes**, select all that apply. Driving involves: Time constraints Delivery Student or youth transportation Outside sales Routine errands Other

How many of the employees regularly using their personal autos are <= 25 years of age?

Indicate the control measures in place: (select all that apply)

Employees carry personal auto insurance liability of at least 100/300/50 (\$100,00/\$300,000/\$50,000 split) or \$300,000 CSL (Combined Single Limit)

Written guidelines requiring minimum age and driving experience before allowing use of personal vehicles in the course of the business

Drivers' MRVs are on file and checked annually to be insured Other No control measure in place

CLAIMS INFORMATION:

Within the past five years have you had any claims on any line of coverage for which you are applying? Yes No

(If Yes, please attach a separate page with claim detail, payment amount, and status of the claim.)

APPLICATION FRAUD WARNING

Any person who knowingly and with the intent to defraud any insurance company or another person files an application containing materially false information, or conceals for the purpose of misleading, information concerning any fact material there to, commits a fraudulent insurance act, which is a crime and subjects the person to criminal and (NY: substantial) civil penalties.

Duty of Disclosure: In addition to providing all basic information necessary to enable us to place the risk, you must ensure that you are complying with your legal duty of disclosure of all material matters relating to the risk. In particular, you must satisfy yourself as to the accuracy and completeness of the information you provide the insurers. In this respect, you must provide all information relating to the risk whether favorable or not, which would influence the judgment of prudent insurer in determining whether they will take the risk, and, if so, for what premium and on what terms. If all such information is not disclosed by you, insurers have the right to void the contract from its commencement, which may lead to claims not being met.

Signature

Date

PLEASE SIGN AND DATE IN INK



Insurance

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