



The Professional Protector Plan® Property Application

1. Please answer all questions. Do not leave any blanks. If a question is not applicable, please write N/A.
2. Application must be signed and dated by applicant.

This is an application for insurance, not an insurance binder. Completion of this form neither binds coverage nor guarantees that a policy will be issued. Additional information may be required upon review of the application.

I agree that any coverage issued will be contingent upon the truth of the following information:

Full Name: _____ DDS DMD MD BDS MS

New Policy Requested Effective Date: ___/___/___

Rewrite of Policy Number: _____

Renewal of Policy Number: _____

Do not answer questions 1-9 if your Professional Liability (PL) is already written by AAIC or if you are also submitting a PL application at this time

PLEASE TELL US ABOUT YOUR PRACTICE

1. Mailing Address: _____
City / State / Zip: _____

2. Telephone Number: _____ 3. Fax Number: _____

4. Email Address: _____ 5. Web Address: _____

6. Under which business structure do you practice?
 Sole Proprietor Limited Liability Company Limited Liability Partnership Incorporated Partnership
 Employee Dentist Name of Employer / Facility: _____
 Independent Contractor
 Name of Employer / Facility: _____

7. Name of your legal entity (if any): _____
 A. Is the sole function / purpose of this entity for the practice of dentistry?..... Yes No
 If **"No"**, please provide details: _____

8. Years in business: _____

9. Are you in a space-sharing arrangement or agreement with another Dentist, Oral / Maxillofacial Surgeon, or other Healthcare Provider not individually insured by AAIC who has access to or will be using your office or dental equipment?..... Yes No

PLEASE TELL US ABOUT YOUR INSURANCE HISTORY

10. Have you ever had any property insurance refused, canceled, or non-renewed?..... Yes No
(THIS QUESTION IS NOT APPLICABLE TO MISSOURI RESIDENTS)

11. Have you had any property claims (fire, burglary, water damage, earthquake, etc.) or employee dishonesty losses during the past three years in excess of \$5,000?..... Yes No
 If **"Yes"**, please give details (cause of loss, amount paid, date of loss) on a separate sheet of paper.

12. Please indicate current property insurance carrier. If none, state "None."

Insurance Carrier	Effective Date	Expiration Date	Limits of General Liability

TELL US ABOUT YOUR PROPERTY (Please complete a separate property supplement for each practice location.)

13. Practice Address:

Street _____ City _____ County _____ State _____ Zip _____

14. Construction of the building you occupy:

- Frame** (exterior walls are wood or other combustible material, or exterior walls are combustible materials combined with other materials such as brick veneer or stucco)
- Joisted masonry** (exterior walls are masonry but floors and roof are combustible)
- Masonry non-combustible** (exterior walls are masonry; floors and roof are metal or other non-combustible materials)
- Non-combustible** (exterior walls, floors, and roof are constructed of, and supported by, metal, asbestos, gypsum or other noncombustible materials)
- Modified fire-resistive** (exterior walls, floors, and roof are masonry or fire resistive materials with fire resistance rating of at least 1 hours but not less than 2 hours)
- Fire-resistive** (exterior walls, floors, and roof are masonry or fire-resistive material with fire resistance rating of at least 2 hours or more)

15. Describe the building in which you are located:

No. of stories	Floor in which you are located	Year built	Total square footage of building without basement	Square footage of your office	Square footage of your basement	Basement finished? <input type="checkbox"/> Yes <input type="checkbox"/> No	Agent Use Only Protection Class

16. If the building is over 25 years – what year was it last updated?

Roof _____ Electrical _____ HVAC _____ Plumbing _____ Gut Renovation _____

17. Is your practice location equipped with any of the following systems?

	Local	Central Station 24- hour monitored	None
A. Sprinkler	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Fire Alarm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Smoke Detectors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Burglar Alarm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Automatic Water Shut Off Valve	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

18. Is the location within 1,000 feet of a fire hydrant?..... Yes No

19. What is your practice location's distance to the nearest fire station?..... _____

20. Is your practice located in your residence?..... Yes No

If "**Yes**", please provide proof of **current** residential coverage.

If "**Yes**", does your office have a separate entrance?..... Yes No

21. Are cash and checks deposited daily?..... Yes No

22. How do you store your cash on hand? Safe Fire restrictive container Other (describe): _____

A. Amount of cash left on premises overnight: \$ _____

23. How do you store your accounts receivable records? Electronically Fire resistive container Other (describe): _____

24. Do you maintain duplicate accounts receivable records?..... Yes No

25. Are accounts receivable duplicates kept off your premises?..... Yes No

26. Are you within 1 mile of an ocean, gulf, or river?..... Yes No

27. Are you less than 10 feet above sea level?..... Yes No

28. Total number of operatories: Fully equipped: _____ Partially equipped: _____ Bays: _____

29. Name and address of Loss Payee or Lessor on contents (i.e., office and dental equipment):

Name	Street	City	State	Zip
Name	Street	City	State	Zip

ESTIMATE THE TOTAL COST TO REPLACE THE DENTAL PRACTICE, PERSONAL PROPERTY, AND INCOME

30. Blanket Practice Contents	Amount of Coverage Desired
A. Furniture and Fixtures	
B. Operatory Equipment	
C. Instruments and Supplies	
D. Improvements and Betterments (Including custom cabinetry) <i>For example, property that would be considered part of the building, which you are responsible for or you are required to insure pursuant to the terms of a lease agreement.</i>	
E. Glass	
F. HVAC (requires purchase of Equipment Breakdown coverage (If required by your lease agreement and building is not owned)	
G. Practice Records/Charts, Accounts Receivables, Valuable Papers, X-Rays (\$25,000 automatically included)	
Total Blanket Practice Contents (must be 100% Replacement Cost):	\$

	Standard Limit	Amount of Coverage Desired
31. Sign not attached to building	\$10,000	
32. Employee Dishonesty: A. Monies and Securities B. Welfare and Pension Plans	\$35,000 \$20,000 inside \$15,000 outside \$25,000	Optional Amounts available: <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$75,000 <input type="checkbox"/> \$100,000
33. Dentist's Electronic Equipment (including Computers/Electronic Data Processing equipment) <i>Higher limits available through Equipment Breakdown coverage option</i> A. Do you use surge protection devices? <input type="checkbox"/> Yes <input type="checkbox"/> No	\$50,000	
34. Theft Coverage for Precious Metals	\$25,000	
35. Fine Arts (attach appraisals for each piece valued over \$1,000 per item limit)	\$30,000	
36. Back up of Sewer or Drain	\$25,000	Optional limits available: <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> Other: \$ _____

37. Business Interruption (VPI) Coverage – Minimum \$1,000 per day / 32.5 days (Profit & Loss [P&L] Statement may be required)

- A. Daily limit desired (minimum \$1,000 required unless P&L provided): \$ _____
- B. Number of days (minimum 32.5, maximum 180): _____
- C. Gross annual income / production (please provide P&L): \$ _____
- D. Average number of days per week the **practice** is open: _____

NOTE: The standard waiting period is 24 hours. Optional extended waiting periods may be available. Please speak to your agent regarding the options available in your area.

38. Property deductibles (subject to state exception): \$500 \$1,000 \$2,500 \$5,000 \$10,000

OPTIONAL PROPERTY COVERAGE ENHANCEMENTS (Additional charges will apply):

39. Would you like to add a Property Enhancement Endorsement? *Contact your agent for details*..... Yes No
 If "Yes", please select one: PPP Gold PPP Platinum
40. Would you like Equipment Breakdown Coverage? Yes, Dental Equipment only Yes, Dental Equipment and HVAC No
 If "Yes", do you own the building?..... Yes No
 A. Value of the building (if you do not own the building, provide estimate of occupied structure): \$ _____
41. Would you like Fungi, Wet Rot, Dry Rot, and Microbe coverage (limit of \$25,000)?..... Yes No
42. Would you like Condominium Unit Owner's Loss Assessment coverage?..... Yes No
 If "Yes", please select a limit: \$1,000 \$5,000 \$10,000 Other: \$ _____

TELL US ABOUT YOUR BUILDING

BUILDING INFORMATION – Complete this only if you desire insurance on the building through this plan	Standard Limit	Amount of Coverage Desired
43. Building – (Current cost to replace)		
A. Additional building on premises (garage, storage building)		
B. Inflation Guard (Must select <u>quarterly</u> increases up to 5% - Contact your agent)		<input type="checkbox"/> 0.3% <input type="checkbox"/> 0.4% <input type="checkbox"/> 0.5% <input type="checkbox"/> 1% <input type="checkbox"/> 1.5% <input type="checkbox"/> 2% <input type="checkbox"/> 2.5% <input type="checkbox"/> 3% <input type="checkbox"/> 3.5% <input type="checkbox"/> 4% <input type="checkbox"/> 4.5% <input type="checkbox"/> 5%
44. Ordinance or Law (Building)	\$100,000	
45. Would you like coverage for your Annual Rental Income?		<input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", Annual Rental Income: \$ _____
46. Have there been any changes in tenants or vacancy?.....		<input type="checkbox"/> Yes <input type="checkbox"/> No
A. Please indicate tenants by type of business and/or operations conducted and square footage for each. If any vacancy, please indicate % of vacancy.		
_____		Sq. Feet % of Vacancy
_____		Sq. Feet % of Vacancy
47. Please indicate the neighboring business types to your building:		
Left _____ Distance _____	Right _____ Distance _____	
Rear _____ Distance _____	Above _____	

TELL US ABOUT YOUR ADDITIONAL INSURED REQUIREMENTS

48. Legal name of Building Owner:

49. Name and address of Mortgagee:

 Name _____ Street _____ City _____ State _____ Zip _____

50. Other Additional Insured(s):

 Name _____ Insurable Interest _____

 Street _____ City _____ State _____ Zip _____

 Name _____ Insurable Interest _____

 Street _____ City _____ State _____ Zip _____

EARTHQUAKE & FLOOD (Coverage is not available in all states and/or zones)

51. Is additional earthquake insurance coverage desired? A \$50,000 limit is automatic in select zones..... Yes No
If **“Yes”**, please check coverage desired:
 Contents/Blanket *
 Contents/Blanket and Building **
52. Is additional flood insurance coverage desired? A \$50,000 limit is automatic in select zones..... Yes No
If **“Yes”**, please check coverage desired:
 Contents / Blanket *
 Contents / Blanket and Building **
- * Business Income coverage is mandatory
** Business Income and Rental Income coverages are mandatory

**DENTAL PRACTICE BUILDOUT / RENOVATIONS (Complete only when minor dental office renovations or build out are taking place)
If structural exposures exist or the project exceeds three months, refer to the Builder’s Risk Application and contact Underwriting.**

53. Is the owner acting as General Contractor?..... Yes No
If **“Yes”**, attach Certificates of General Liability and Workers’ Compensation for all Subcontractors.
If **“No”**, attach Certificates of General Liability and Workers’ Compensation from the General Contractor.
- Name of General Contractor: _____
- Insurance Carrier: _____
- Limits: _____
- Policy Period: _____
- Is Contractor experienced in this type of construction? Yes No
54. Estimated project duration _____ Days (OR) _____ Months
55. Value of Construction (materials and labor) \$ _____
56. Confirm the project DOES NOT involve any demolition _____ (Initial)
57. Confirm the project DOES NOT involve any structural changes or load bearing walls _____ (Initial)

Provide a written summary of the project or attached a copy of the construction contract/bid with your application.

AUTHORIZATION

I hereby acknowledge that the aforementioned statements and answers are correct and complete. I agree that any coverage issued will be contingent upon the truth of the preceding information. I further understand that any incorrect or incomplete statement could invalidate my coverage. I hereby authorize AAIC to release the information on this application and associated underwriting information.

FRAUD NOTICE – WHERE APPLICABLE UNDER THE LAW OF YOUR STATE

NOTICE TO APPLICANTS OF ALL STATES EXCEPT COLORADO, DISTRICT OF COLUMBIA, KANSAS, KENTUCKY, LOUISIANA, MAINE, NEW JERSEY, NEW MEXICO, NEW YORK, OHIO, OKLAHOMA, OREGON, PENNSYLVANIA, PUERTO RICO, TENNESSEE, VERMONT, VIRGINIA, WASHINGTON: Any person who knowingly, and with the intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any material false information or conceals for the purposes of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties and denial of insurance benefits. **NOTICE TO COLORADO APPLICANTS:** IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES. **NOTICE TO DISTRICT OF COLUMBIA APPLICANTS:** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially

related to a claim was provided by the applicant. **NOTICE TO NOTICE TO KANSAS APPLICANTS:** an act committed by any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto. **NOTICE TO KENTUCKY APPLICANTS:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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. **NOTICE TO LOUISIANA APPLICANTS:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **NOTICE TO MAINE AND WASHINGTON APPLICANTS:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits. **NOTICE TO MARYLAND APPLICANTS:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **NOTICE TO MINNESOTA APPLICANTS:** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime. **NOTICE TO NEW JERSEY APPLICANTS:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties. **NOTICE TO NEW MEXICO APPLICANTS:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties. **NOTICE TO NEW YORK APPLICANTS:** Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim 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 and is subject to a civil penalty not to exceed \$5,000.00 and the stated value of the claim for each such violation. **NOTICE TO OHIO APPLICANTS:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. **NOTICE TO OKLAHOMA APPLICANTS:** Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer or makes a claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony. **NOTICE TO OREGON APPLICANTS:** Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact, may be violating state law. **NOTICE TO PENNSYLVANIA APPLICANTS:** Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any material false information or conceals for the purposes of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties. **NOTICE TO PUERTO RICO APPLICANTS:** The Entity understands that according to the Insurance Code of Puerto Rico (Article 27.320): "Any person who knowingly and with the intention to defraud that present false information in an insurance request or, that present, make or help to make a fraudulent claim for the payment of a loss or another benefit, it will present more than a claim by a same damage or loss, will incur in a serious crime and could be convicted and sanctioned, by each violation with a pain of no smaller fine of five thousand (\$5,000) dollars, nor greater of ten thousand (\$10,000) dollars or imprisonment by a fixed term of three (3) years, or, both pains. If there are aggravating circumstances, the pain fixes established could be increased until a maximum of five (5) years; to mediate extenuating circumstances, it could be reduced until a minimum of two (2). **NOTICE TO TENNESSEE AND VIRGINIA APPLICANTS:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits. **NOTICE TO VERMONT APPLICANTS:** Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Signature in full Date

Agent's Signature Date

If you apply your signature to this application electronically, you hereby consent and agree that your use of a key pad, mouse or other device to affect your electronic signature constitutes your signature, acceptance and agreement as if actually signed by you in writing and has the same force and effect as a signature affixed by hand.

AGENCY INFORMATION

RETURN TO:		
State Administrator Name: _____		
Address: _____		
City: _____	State: _____	Zip Code: _____
Phone #: _____	Agent's License Number: _____	

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