

AAO ENDORSED BUSINESS INSURANCE APPLICATION

Your Name: _____ Date: ____/____/____
 Company Name: _____
 Address: _____ City: _____
 County: _____ State: _____ Zip: _____
 Phone Number: (____) _____ Fax Number: (____) _____
 E-mail Address: _____

Date new coverage
 needs to be effective
 ____/____/____

Describe Your Business:

Legal Entity: Corporation LLC Partnership Individual Other _____
 Please provide a complete description of your business: _____

 Year Business Purchased/Began: _____ FEIN (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.

Property and Coverage Information:

Please tell us about each of your locations. (Please copy this page and complete for each additional location, use as many pages as needed.)

Location Number: _____ of _____
 Location Address: Same as the company address Yes No
 How many stories? _____
 Approx. total building sq. ft: _____
 Are there other businesses in same building? Yes No
If Yes, please provide a complete description of the other businesses.

If No, please enter the building address:
 Street: _____
 City: _____
 County: _____ State: _____ Zip: _____
 Sq. ft. occupied by you: _____ sq. ft.
 What year was the building built? _____
 If older than 20 years, please enter the year any updates were made to the building:
 Rewired _____ Reroofed _____
 Replumbed _____ Heater replaced _____

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
 For this building are you the The Owner? A Tenant
 Deductible (please choose one): \$250 \$500
 \$1,000 \$2,500

Coverage Requested:

Building Replacement Cost At 100% (if owned):	\$ _____
Tenant's Improvements and Betterment	\$ _____
Business Contents <i>(indicate cost to replace with new equipment in the event of a total loss):</i>	
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 Insureds):

Name & Address	Relationship with Insured
_____	_____
_____	_____

Please complete the sections below for which your business would like quoted.

Umbrella Liability:

In an increasingly litigious society, 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 _____

Workers Compensation:

Annual Payroll: _____ Number of Employees: Full Time _____ Part Time _____

Desired Effective Date _____ Leased/Contracted _____

Are officers to be included for Workers Compensation coverage? Yes No

If Yes, please include payroll in total above.

Please list the names of the owners/officers and their titles (use a separate sheet, if necessary):

Name	Title
_____	_____
_____	_____
_____	_____

Employment Practices Liability Insurance (EPLI):

If you employ one or more employees you are at risk for an employment practice liability claim!

Examples of Employment Practices Liability claims include: Wrongful termination, Sexual Harassment, Discrimination, Failure to Promote

Please indicate if you are interested in receiving an indication for EPLI? Yes No

If yes, and you are not applying for worker's compensation, how many employees do you currently have? _____

Employment Retirement Income Security Act (ERISA):

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

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

Official Name of Retirement Plan: _____

Desired Effective Date _____

Commercial Auto:

Does your business own/lease any auto(s) in which your business is listed on the title? Yes No

(If Yes, and you are interested in receiving a quote, please attach a current copy of your auto declaration page including a schedule of covered autos.)

Claims Information:

Within the past 5 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 fax completed application to: 312-360-9237 or
Mail to: Plan Administration Office, 159 E. County Line Road, Hatboro, PA 19040
Questions call: 1- 800-622-0344