COA BUSINESS OWNERS PACKAGE / PROFESSIONAL LIABILITY APPLICATION

3-961w

How to request a quote: complete this form, select the coverages you desire, and mail/fax to the address provided. Please print or type all information. If you would like assistance completing the form, call **800-775-2020.**

1.) GENERAL APPLICANT INFORMATION

Requested Effective Date:_____________________

Named Insured is: ☐ Individual ☐ Corporation ☐ Partnership ☐ Joint Venture ☐ Other:___________________________________

Named Insured is: ☐ Self Employed ☐ Employee Optometrist ☐ Independent Contractor ☐ First Year Graduate __________(Date Graduated)

If you are an Employee Optometrist, list name of employer____

Business/Corporate Name, DBA, or Your Name, if not incorporated | Federal Tax I.D. # or Social Security #

Name of Owners, Partners, and Corporate Officers who are active in the business, their professional occupation and their social security numbers.

Street Address | Daytime Phone | Fax Number

City | County | State | Zip Code

Location Address, if other than above: Please list additional locations on a separate sheet and attach.

Street Address

City | County | State | Zip Code

Interest In Premises:

☐ Lessee
☐ Owner/Occupant
☐ Owner/Lessor
☐ Condo Owner

2.) BUSINESS OWNERS PACKAGE

Indicate limits of coverage you require in addition to the limits or coverages indicated below, for each location:

PROPERTY COVERAGES	LIABILITY COVERAGES
Includes Business Income/Extra Expense — Actual Loss Sustained —	A separate policy must be issued for Professional Liability for the selected limits of liability.
Coverage A Building $________________ Replacement Cost **Coverage B** Contents $________________ Replacement Cost Deductible Per Policy: ☐ $500 ☐ $1000 ☐ $2500 ☐ $5000 Includes the following: Accounts Receivable . . . . $25,000 or $___________ Valuable Papers . . . . $25,000 or $___________ Personal Property Off Premises . . . . . $2,500 or $___________ Computer..EDP, software . . . . $10,000 or $___________ Employee Dishonesty . . . . $10,000 or $___________	**Coverage C** — Business Liability Limits of Insurance ☐ $1,000,000 per occurrence/ $3,000,000 annual aggregate ☐ $2,000,000 per occurrence/ $4,000,000 annual aggregate **Coverage D** — Medical Payments $10,000 Per Person (included) **Annual Receipts:**_________________________________ **Includes:** Tenant's Legal Liability Limited Glass Coverage $1,000 Maximum **Optional:** Employee Benefits Liability $10,000 or $ ____________ Full Glass Coverage (Value of Glass) $ ____________ Umbrella $ ____________ million Hired and Non-Owned Auto 4/09

Additional Insureds:
☐ Loss Payee ☐ Additional Named Insured
☐ Mortgagee ☐ Leased Equipment Lessor

(If more than one, please provide name(s) and address(es) on a memorandum.)

Name____

Address ____

____

____

Has the Insured agreed to name anyone as an Additional Insured?
ie: Landlord? ☐ Yes ☐ No
Additional Insured's interest: ______________________________

(If more than one, please provide name(s), address(es) and interest on a memorandum.)

Name____

Address ____

____

____

Prior Carrier Information — Business Owners

Policy Term From/To	Insurance Company	Policy Number

Any policy or coverage declined, cancelled, non-renewed or placed in a non-standard market in the past 3 years? ☐ Yes ☐ No If yes, explain.

Loss Information (list all prior claims reported to carrier within 3 years — attach list if necessary)

Include Property and Liability. ☐ No prior losses in 3 years.

Loss Date	Description of Loss	$ Amount Paid	$ Reserve	Open	Closed

To the best of your knowledge are there any incurred but not reported claims? ☐ Yes ☐ No If yes, explain.

Complete This Section for Each Location

Construction:
☐ Frame
☐ Joisted Masonry
☐ Non-Combustible
☐ Masonry Non-Combustible
☐ Modified Fire-Resistive
☐ Fire-Resistive

Building Occupancy:
☐ Single
☐ Multiple
If multiple, list other occupants:____________
____
____

Is Building 75% Sprinklered?
☐ Yes
☐ No

Total Bldg. Area: ______________________Sq. Ft

Area Occupied by Insured: _______________Sq. Ft.

Basement(s): ____________________________

Building • Year Building Built __________ • Number of Stories __________

If building is more than 25 years old, have the wiring, plumbing and heating-A/C and/or roofing systems been partially or completely updated or replaced? ☐ Yes ☐ No If yes, provide the year updated or replaced:
Wiring:__________ Plumbing:_________ Heating:___________ Roof:__________ Comprehensive Renovation:__________

Note: Comprehensive Renovation Year reflects when the building was gutted to the exterior walls and completely rebuilt with new interior walls, plumbing, heating, wiring and roof.

Protection

- Number of fire extinguishers _____________
- Smoke Detectors installed? . . . . ☐ Yes ☐ No
  Hardwired? . . . . ☐ Yes ☐ No
- Burglar alarm? . . . . ☐ Yes ☐ No
  Type: ☐ local ☐ silent ☐ central station
- Fire alarm? . . . . ☐ Yes ☐ No
  Type: ☐ local ☐ silent ☐ central station

Management

- Year this business started ____________ Year
- Total number of employees: __________ Full Time
  __________ Part Time

4/09

3.) PROFESSIONAL LIABILITY

Per Incident	☐ $1,000,000	OR	☐ 2,000,000
Annual Aggregate	$3,000,000		4,000,000

Prior Carrier Information — Professional Liability

Policy Term From/To	Insurance Company	Policy Number

Any policy or coverage declined, cancelled, non-renewed or placed in a non-standard market in the past 3 years? ☐ Yes ☐ No If yes, explain.

Loss Information (list all prior Professional Liability claims within 3 years — attach list if necessary)

Include Property and Liability. ☐ No prior losses in 3 years.

Loss Date	Description of Loss	$ Amount Paid	$ Reserve	Open	Closed

To the best of your knowledge are there any incurred but not reported claims? ☐ Yes ☐ No If yes, explain.

1) List names of optometrists in your office (including yourself) to be covered: *(if you need additional space please use Remarks section on page 4.)*

______________________________ ☐ Full Time ☐ Part Time

______________________________ ☐ Full Time ☐ Part Time

______________________________ ☐ Full Time ☐ Part Time

2) Have any of the following ever been revoked, suspended, refused, denied renewal, placed on probation, cancelled or voluntarily surrendered by you or any of your employees? *(If "Yes", explain on a separate sheet of your letterhead and attach to the application.)*

State License or Certification ☐ Yes ☐ No

Malpractice Insurance ☐ Yes ☐ No

3) Has any claim or suit ever been brought against you or any of your employees, or are you or any of your employees aware of any incident that might reasonably lead to a claim or suit? ☐ Yes ☐ No
(If "Yes", explain on a separate sheet of your letterhead. Please include dates, allegations and amounts.)

4.) PROVIDER CONTRACTS

☐ Vision Service Plan	☐ Other________________
☐ AVP	☐ Other________________
☐ Cole Vision	☐ Other________________
☐ Davis Vision	☐ Other________________
☐ Block Vision	☐ Other________________
☐ Medical Eye Services (MES)	☐ Other________________

5.) SIGNATURE

Any person who knowingly and with intent to defraud any insurance company or another 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 and subjects the person to criminal and civil penalties.

I authorize Marsh to collect, use and disclose loss run information from my former Business Owners Package insurance policies solely for the purpose of obtaining proposals on my behalf from the program insurers. They are authorized to release to prospective insurers the name of my current insurer, pricing and policy terms. They may also release to prospective insurers the results of other competitive bids in order to allow an insurer to submit an improved quote. I will advise Marsh in writing if I do not want any of the above information released.

Signature________________________________ Date:________________

MARSH

MMC MARSH MERCER KROLL GUY CARPENTER OLIVER WYMAN

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6.) REMARKS