



The Professional Protector Plan® Monoline Property Supplement



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 in ink.

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

New Policy	Requested Effective Date: ____/____/____
Renewal of Policy Number: _____	
Rewrite of Policy Number: _____	

PLEASE TELL US ABOUT YOURSELF

1. Name: (First/Middle Initial/Last/Designation) DDS ◊ MD MD BDS				2. Date of Birth:	
_____				_____	
3. Mailing Address:					

Street		City		State	
				Zip Code	
4. Telephone Number:		5. Fax Number:		6. E-mail Address	
(____) _____		(____) _____		_____	
7. Years in Business:		8. Business Structure of your practice: Sole proprietor Incorporated L. L. C.			
_____		L. L. P. Partnership Professional Association Professional Corporation			
		Other (describe) _____			
9. Name of Legal Entity:					

PLEASE TELL US ABOUT YOUR INSURANCE HISTORY

10. Have you ever had any property insurance refused, cancelled or non-renewed?..... Yes No				
If "Yes", provide dates and reason: (NOT APPLICABLE TO MISSOURI RESIDENTS)				

11. Have you had any property losses (fire, burglary, water damage, premises, earthquake, etc.) or employee dishonesty losses during the past three (3) years?..... 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."				
Carrier	Effective Date	Expiration Date	Policy Type Building, Contents or Both	Limit of Insurance

PROPERTY INFORMATION (Please complete a separate property supplement for each practice location.)

13. Practice Address:

 Street City County State Zip Code

Describe the building in which you are located:

Construction of Building you occupy	No. of Stories	Floor on Which You Are Located	Year Built	Total Sq. Footage of Building	Square Footage of Your Office	Square Footage of Basement(s)	Basement (s) Finished	Agent Use Only Protection Class
							YES NO	

14. If the building is over 25 years of age, please indicate the year the building was updated: _____

Year Roof Updated _____
 Electric Meets Building Codes Yes No
 Building was built for a different occupancy and has been modified Yes No If Yes, please describe: _____

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

YES **NO**
Local Central Station

- a. Sprinkler.....
- b. Fire alarm.....
- c. Smoke detectors.....
- d. Burglar alarm.....

16. Is your practice located in your residence? Yes No
 If "Yes," does your office have a separate entrance? Yes No

17. A. What is your practice location's distance to the nearest fire station?
 _____miles
 B. Is the location within 1,000 feet of a fire hydrant?..... Yes No

18. Do you utilize a watchman service?..... Yes No

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

20. How do you store your cash on hand?
 Safe Fire Resistive Container Other (describe) _____
 A. Amount of cash left on premises overnight.....\$

21. How do you store your accounts receivable records?
 Computer Fire Resistive Container Other (describe) _____

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

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

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

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

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

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

Name	Street	City	State	Zip Code
Name	Street	City	State	Zip Code

28. Which coverage do you prefer? **Please contact your agent for information**

PPP Standard

PPP Gold (**An additional charge applies**) Includes Unauthorized Business Card Use, Computer Fraud, Claims Data Expenses and other valuable coverages

Estimate the total cost to replace Dental Practice Personal Property:	PPP Standard	Amount of Coverage Desired
A. Practice Contents:		
1. Furniture and fixtures.....		+ _____
2. Operatory equipment.....		+ _____
3. Instruments and supplies.....		+ _____
4. Improvements and betterments.....		+ _____
5. Glass.....		+ _____
6. Other _____		+ _____
Practice Contents Subtotal (100% Replacement cost).....		\$ _____
B. Practice Records/Charts, Account Receivables, valuable Papers, X-Rays:\$25,000 minimum		+ _____
C. Dental Practice Blanket Limit Total (A + B)		+ _____
D. Signs not attached to building\$10,000.....		+ _____

29. Inflation Guard – Dental Practice Personal Property.....Optional.....	_____ %
(May select quarterly increase from 1% - 5%)	Quarterly
30. Valued Practice Income.....	\$ _____ / _____
Minimum daily limit of \$300 32.5 days	Daily Limit / # days
31. If a value practice income limit is selected, please provide your gross annual production.....	\$ _____
Number of days per week the practice is open.....	_____
(Profit and loss statement may be required)	
32. Rents (annual rental income).....Optional.....	\$ _____
33. Employee Dishonesty:	
a. money/securities.....\$25,000.....	\$ _____
b. welfare and pension plans.....\$25,000.....	\$ _____
34. Dentist's Electronic Equipment (including Electronic Data Processing equipment)..... \$50,000.....	\$ _____
Do you use surge protection devices?.....	Yes No
35. HVAC Equipment Breakdown Coverage	\$ _____
Do you own the building in which your office is located? Yes No	
Building value	\$ _____
36. Fine Arts (attach appraisals, if additional coverage is desired).....\$25,000.....	\$ _____
maximum \$1,000 per item	
37. Back up of Sewer or Drain	\$ _____
38. Have you had any coverage declined or property losses (fire, burglary, water damage, premises, earthquake, etc.) or employee dishonesty losses during the past three (3) years?.....	
If "Yes", please give details (cause of loss, amount paid, date of loss) on a separate sheet of paper.	Yes No
39. Property Deductible - \$250 (Optional Deductibles of \$500, \$1,000, \$2,500, \$5,000 and \$10,000 available	\$ _____

BUILDING INFORMATION - Complete questions 40 – 47 only if you desire insurance on the building through this plan.

40. Building --- (Current Cost to Replace).....		\$ _____
a. additional buildings on premises (garage, storage building).....		\$ _____
b. inflation guard (may select quarterly increase from 1% - 5%)	Mandatory	_____ % Quarterly
41. Ordinance or Law (Building).....	\$100,000.....	\$ _____

42. Please indicate % of vacancy, or tenants by type of business and/or operations conducted, and square footage for each:

	Sq. feet:	
	Sq. feet:	

43. Is your building located on a known land subsidence area?..... Yes No

44. Is your building resting on a saturated man-made (filled ground) or alluvial (soft) soil? Yes No

45. Name of building owner: _____

46. Name and address of Mortgagee:

Name	Street	City	State	Zip Code
Name	Street	City	State	Zip Code

47. Describe the occupant to the right of your building, including distance.	Describe the occupant to the left of your building, including distance.	Describe the occupant to the rear of your building, including distance.

OPTIONAL COVERAGES (Coverage is not available in all states and/or zones)

Notes: * Business Income coverage is mandatory
 ** Business Income and Rental Income coverages are mandatory

48. Is earthquake insurance coverage desired? If Yes, please advise of coverage desired.	Yes	No
* Contents/ Blanket: ** Contents/ Blanket and Building:		

49. Is flood insurance coverage desired? If Yes, please advise of coverage desired.	Yes	No
* Contents/ Blanket including electronic equipment: ** Contents/ Blanket including electronic equipment and Building:		

I hereby acknowledge that the aforementioned statements and answers are correct and complete. I further understand that any incorrect or incomplete statement could void my protection. I hereby authorize the CNA Insurance Companies to release the information on this application and associated underwriting information.

FRAUD NOTICE – WHERE APPLICABLE UNDER THE LAW OF YOUR STATE

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 or incomplete information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES (For District of Columbia residents only: 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.) (For Florida residents only: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.) (For Louisiana residents only: 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.) (For Maine residents only: 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.) (For New York residents only: and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.) (For Pennsylvania residents only: 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 subjects such person to criminal and civil penalties.) (For Tennessee residents only: Penalties include imprisonment, fines and denial of insurance benefits.) (For Vermont residents only: 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 or incomplete information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which may be a crime and may be subject to civil fines and criminal penalties.) (For Washington residents only: 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.)

Signature in full: _____

Date _____

REMINDER:

Please attach a sample of your letterhead and a copy of all of your dental practice "Yellow Pages" advertising, if any, to this application.

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

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