



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:

<input type="checkbox"/> New Policy	Requested Effective Date ____/____/____	<input type="checkbox"/> Rewrite of Policy Number _____
<input type="checkbox"/> Renewal of Policy Number: _____	<input type="checkbox"/> Web Address: _____	

PLEASE TELL US ABOUT YOURSELF

1. Full Name: _____	<input type="checkbox"/> DDS	<input type="checkbox"/> DMD	<input type="checkbox"/> MD	<input type="checkbox"/> BDS
2. Mailing Address: _____				
City/ State / Zip _____				
3. Telephone Number: (____) _____				
4. Fax Number: (____) _____				
5. E-mail Address: _____				

PLEASE TELL US ABOUT YOUR PRACTICE

6. Under which business structure do you practice?				
<input type="checkbox"/> Sole Proprietor	<input type="checkbox"/> Limited Liability Company	<input type="checkbox"/> Limited Liability Partnership	<input type="checkbox"/> Incorporated	<input type="checkbox"/> Partnership
<input type="checkbox"/> Employee Dentist	Name of Employer/Facility: _____			
<input type="checkbox"/> Independent Contractor	Name of Employer/Facility: _____			
7. Name of Legal Entity: _____				
8. Years in Business: _____				

PLEASE TELL US ABOUT YOUR INSURANCE HISTORY

9. Have you ever had any property insurance refused, cancelled, or non-renewed?					<input type="checkbox"/> Yes	<input type="checkbox"/> No
10. Have you ever had any property losses (fire, burglary, water damage, premises earthquake, etc.) or employee dishonesty losses during the past three years?					Yes	<input type="checkbox"/> No
If "Yes", please give details (cause of loss, amount paid, date of loss) on a separate sheet of paper.						
11. Please indicate current property insurance carrier. If none, state "None."						
Insurance Carrier	Effective Date	Expiration Date	Claims-made or Occurrence	Limits of Liability		

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

12. Practice Address

Street _____ City _____ County _____ State _____ Zip Code _____

13. Construction of the Building you occupy:
 Frame Joisted Masonry Non-Combustible Masonry Non-Combustible Modified Fire Resistive Fire Resistive

14. Describe the building in which you are located:

No. of Stories	Floor in which you are located	Year Built	Total Square Footage of the Building	Square Footage of Your Office	Basement Finished? <input type="checkbox"/> YES <input type="checkbox"/> NO	Agent Use Only Protection Class

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

Year roof updated?	Electric Meets Building Code?	Plumbing is maintained to prevent exposure to leaking or frozen pipes?	Building was designed for a different occupancy and has been modified?
<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES If yes, what was building designed for: _____ _____ <input type="checkbox"/> NO

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

	Local	Central Station	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"/>

TELL US ABOUT YOUR LOCATION

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

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

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

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

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

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

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

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

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

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

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

28. 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 _____

29. Which coverage do you prefer?
 PPP Standard
 PPP Gold Includes Unauthorized Business Card Use, Computer Fraud, Claims Data Expense, and other valuable coverages) (Please contact your agent for information on this valuable coverage)

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

30. Practice Contents	Amount of Coverage Desired
A. Furniture and Fixtures	
B. Operatory Equipment	
C. Instruments and Supplies	
D. Improvements and Betterments	
E. Glass	
F. Other	
Practice Contents Subtotal (100% Replacement Cost):	\$

	Standard Limit	Amount of Coverage Desired
31. Practice Records/Charts, Account Receivables, Valuable Papers, X-Rays:	\$25,000	
32. Dental Practice Blanket Limit Total (total 30 & 31)		
33. Signs not attached to building	\$ 10,000	
34. Inflation Guard – (Dental Practice Personal Property (May select quarterly increases up to 5% - Contact your agent)	Optional	Quarterly: ____%
35. Do you desire Business Interruption (VPI) Coverage? (Profit and Loss Statement may be required) If "Yes", provide: A. daily limit desired B. number of days C. gross annual income/production: D. average number of days per week the practice is open:	<input type="checkbox"/> Yes <input type="checkbox"/> No A. \$ _____ B. _____ C. \$ _____ D. _____	
36. Employee Dishonesty:		
A. Monies and Securities:	\$ 25,000	
Optional Amounts available: <input type="checkbox"/> \$ 50,000 <input type="checkbox"/> \$ 75,000 <input type="checkbox"/> \$100,000		
B. Welfare and Pension Plans:	\$25,000	
Other amount requested:		
37. Dentist's Electronic Equipment (including Electronic Data Processing equipment)	\$ 50,000	
A. Do you use surge protection devices?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	
38. Fine Arts (subject to maximum of \$1,000 per item; attach Appraisals for each piece valued over \$ 1,000)	\$ 25,000	
39. Back up of Sewer and Drain	\$ 25,000	
Optional limits available <input type="checkbox"/> \$ 50,000 <input type="checkbox"/> \$100,000		
40. Equipment Breakdown Coverage?		
A. <input type="checkbox"/> Dental Equipment only <input type="checkbox"/> Dental Equipment and HVAC B. Do you own the Building?..... C. Value of the Building?.....	B. <input type="checkbox"/> Yes <input type="checkbox"/> No C \$ _____	
41. Property Deductibles - Subject to State Exceptions		
Deductibles Available: <input type="checkbox"/> \$ 250 <input type="checkbox"/> \$ 500 <input type="checkbox"/> \$ 1,000 <input type="checkbox"/> \$ 2,500 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$ 10,000		

TELL US ABOUT YOUR BUILDING

BUILDING INFORMATION - Complete only if you desire insurance on the building through this plan.	Standard Limit	Amount of Coverage Desired
42. Building --- (Current Cost to Replace)		
A. Additional buildings on premises (garage, storage building)		
B. Inflation guard (May select quarterly increases up to 5% - Contact your agent)	Mandatory	Quarterly: _____%
43. Ordinance or Law (Building)	\$100,000	
<p>44. Has there been any changes in tenants or vacancy?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>A . Please indicate tenants by type of business and/or operations conducted and square footage for each. If any vacancy, please indicate % of vacancy</p> <p>_____ Sq. Feet _____</p> <p>_____ Sq. Feet _____</p> <p>B. % of Vacancy</p> <p>_____ Sq. Feet _____</p> <p>_____ Sq. Feet _____</p>		
<p>45. Is your Building: A. located on a known land subsidence area?..... Yes No</p> <p>B. resting on a saturated man-made (filled ground) or alluvial (soft) soil? Yes No</p>		
46. Legal Name of Building Owner: _____		
47. Name and address of Mortgagee:		
_____	_____	_____
Name	Street	City State Zip Code
_____	_____	_____
Name	Street	City State Zip Code
48. 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.

Earthquake and Flood (Coverage is not available in all states and/or zones)

<p>49. Is earthquake insurance coverage desired? Yes No</p> <p>If "Yes", please check coverage desired:</p> <p>* Contents/ Blanket: <input type="checkbox"/></p> <p>** Contents/ Blanket and Building: <input type="checkbox"/></p>
<p>50. Is flood insurance coverage desired? Yes No</p> <p>If "Yes", please check coverage desired:</p> <p>* Contents/ Blanket: <input type="checkbox"/></p> <p>** Contents/ Blanket and Building: <input type="checkbox"/></p>
<p>* Business Income coverage is mandatory</p> <p>** Business Income and Rental Income coverages are mandatory</p>

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 Oklahoma residents only: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.) (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 Puerto Rico residents only: Any person who knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine of no less than five thousands dollars (\$5,000) nor more than ten thousands dollars (\$10,000); or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.) (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

Agent's Signature:

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: _____		

The Professional Protector Plan® is a registered trademark of B & B Professional Plan, Inc.®. Coverage is underwritten by Continental Casualty Company, one of the CNA property/casualty insurance companies. CNA is a registered service mark and trade name of CNA Financial Corporation.