APPLICATION

TripleGuard™ Insurance Associate

ADVICE. INSURANCE. INVESTMENTS.

For assistance in filling out this application call: **CDSPI Advisory Services Inc.**
1.800.561.9401 or 416.296.9401, E-mail: insurance@cdspi.com

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Please complete all pertinent questions to avoid processing delays and return to:
CDSPI, 155 Lesmill Road, Toronto, ON M3B 2T8 Fax: 1.866.337.3389 or 416.296.8920

Note: Building Insurance is available for an extra premium to dentists who own their dental practice building. Contact CDSPI Advisory Services Inc. to request an application or download one at www.cdspi.com.

INDIVIDUAL INFORMATION

Section 1 Applicant Information

1. Name (*please print*):
Check one: ☐ Dr. ☐ Partnership ☐ Corporation

Last (*or name of partnership or corporation*) First Middle or Middle Initial

2. Individuals only: ☐ Male ☐ Female

3. Mailing Address:
Check one: ☐ Home ☐ Business

Street and Number Suite No.

City/Town Province Postal Code

4.

Business Telephone Home Telephone

Mobile Telephone Fax

5. E-mail address (*please include to expedite the application process*)

6. Language Preference: ☐ English ☐ French

7. A. Account Number, if known: ⌊ | | | | | ⌋

B. Billing Preference (*check one*):
- ☐ Same as current
- ☐ Annually
- ☐ Quarterly
- ☐ Monthly*
- ☐ Pre-authorized Chequing*
- ☐ Automatic VISA/MasterCard*

** To pay monthly, quarterly or annually under this option, you must complete and send in a pre-authorized payment plans form. To obtain this form, visit www.cdspi.com.*

Note: A 2.23 per cent processing charge applies to monthly and quarterly payments.

Section 2 Party To Be Insured

Note: Please complete even if the party to be insured is the same as the applicant.

1. Name (*please print*):
Check one: ☐ Dr. ☐ Partnership ☐ Corporation

Last (*or name of partnership or corporation*) First Middle or Middle Initial

2. Individuals only: ☐ Male ☐ Female

3. Individuals only: Birthdate: ⌊ | | | | | | | | ⌋
Day Month Year

4. If party to be insured is a partnership or corporation, please list the names of all partners or shareholders involved who are dentists:

Name	Status	Year of Graduation	Name of University or Dental Faculty
	☐ Member of Provincial/Territorial Dental Association* ☐ Member of CDA		
	☐ Member of Provincial/Territorial Dental Association* ☐ Member of CDA		
	☐ Member of Provincial/Territorial Dental Association* ☐ Member of CDA		

** Excluding the ACDQ in Quebec.*

Note: If necessary attach a separate page, and sign and date it.

Section 3 TripleGuard™ Insurance Associate Package

TripleGuard™ Insurance Associate Package includes:
Office contents coverage ($15,000 coverage with a deductible of $1,000), practice interruption coverage based on your actual loss sustained, and $5-million of commercial general liability coverage. Note: There is no coverage for loss or damage caused by earthquake.

1. Location(s) to be insured (*if different than in Section 1*)**:**

A. _____
Street and Number Suite No.

_____
City/Town Province Postal Code

B. _____
Street and Number Suite No.

_____
City/Town Province Postal Code

Note: If you are applying for insurance for more locations, please use a separate page to list the other location(s), sign and date it and attach the page to this application.

2. Effective date of coverage: ⌊ | | | | | | | | ⌋
Day Month Year

3. Pandemic Outbreak† Extension:

TripleGuard™ Insurance automatically includes up to $1,000 per day pandemic extension coverage up to a $20,000 annual aggregate limit (see the TripleGuard™ Insurance plan sheet for further details). To apply for additional coverage, check one of the following:

☐ up to $2,500 per day (up to $50,000 annual aggregate limit)
☐ up to $5,000 per day (up to $100,000 annual aggregate limit)

† Pandemic outbreak means an outbreak of an infectious disease resulting in serious illness that becomes prevalent over the human population throughout a region. Pandemic outbreak coverage is only available under the TripleGuard™ Insurance plan and cannot be purchased separately.

4. **Do you want Equipment Breakdown coverage?** For an additional premium, this option insures mechanical or electrical equipment that you own such as patient chairs, X-ray equipment, copiers and more, for repair or replacement needed due to a sudden and accidental breakdown of the equipment due to an insured peril, subject to a $1,000 deductible. In addition, if a loss of your income results from equipment breakdown within the practice you are working in, caused by an insured peril, your income is insured, after the first 8 hours of lost income.
☐ **(check if desired)**

5. Additional insured (e.g. landlord, leasing company, only if they are required to be named under the terms of your lease or contract as an additional insured with regards to liability insurance only):

_____
Additional Insured's Name

_____
Street and Number Suite No.

_____
City/Town Province Postal Code

Note: To name other additional insureds, please attach a separate page and sign and date it.

6. Loss Payable: Name and address of lender or leasing company, if any, to be named as a "loss payee":

_____
Loss Payee's Name

_____
Street and Number Suite No.

_____
City/Town Province Postal Code

Note: To name other loss payees, please attach a separate page and sign and date it.

Section 4 Claims History (Must check "Yes" or "No" for this application to be processed)

1. Have you or anyone named in Section 1, Question 1 or Section 2, Question 1 or Question 4 experienced any losses in the last three years at any of the locations named in this application? ☐ **Yes** ☐ **No**
If "Yes", please complete the following chart (if necessary, please attach a separate page and sign and date it):

Type of loss (*please describe*)	Date of loss	Amount of loss ($)	If precautions have been taken to prevent future losses, please describe

DECLARATION AND AUTHORIZATION

Section 5 To Be Read, Signed and Dated By the Applicant

(If the applicant is a partnership or corporation, one dentist who has been authorized to do so must sign his/her name on behalf of the partnership or corporation.)

I apply to Aviva Insurance Company of Canada for the insurance indicated on this application. The information provided by me is true and complete and the Aviva Insurance Company of Canada may rely on it in issuing insurance coverage to me. I acknowledge receipt of and confirm my agreement with the Notice on Privacy and Confidentiality set out below. A photocopy or facsimile of this authorization shall be as valid as the original.

_____ Date: _____

Signature Day Month Year

AVIVA *TripleGuard™ Insurance is underwritten by Aviva Insurance Company of Canada.*

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NOTICE ON PRIVACY AND CONFIDENTIALITY – **Must be detached, read and retained by the person to be insured**

Aviva Insurance Company of Canada is committed to protecting your personal information and using or disclosing it only for the purposes for which it is collected. When you apply for insurance, consumer and previous insurance reports containing personal, credit, factual, investigative or previous claim and loss information about you may be sought in connection with these matters. By submitting your application, you consent to Aviva collecting, using or disclosing personal information collected in connection with this application. If you wish to withdraw your consent you must notify Aviva immediately in writing. For more information about how Aviva uses and protects your personal information, please refer to Aviva's privacy statement at www.avivacanada.com. You may request to review and make corrections to the personal information in the insurer's file by writing to Aviva Canada Inc., Attention: Privacy Officer, 10 Aviva Way, Suite 100, Markham, ON L6G 0G1, or sending an e-mail to CAPrivacyOfficer@aviva.com.

Access to information which you provide to CDSPI or CDSPI Advisory Services Inc. will be restricted to those employees, mandataries, administrators, agents or brokers who are responsible for underwriting, marketing and administration of services and the processing, facilitating and investigation of claims and to any other person you authorize or as authorized by law. You may request to review and make corrections to the personal information contained in your file at CDSPI or CDSPI Advisory Services Inc. by writing to: The Chief Privacy Officer, 155 Lesmill Road, Toronto, ON M3B 2T8.