APPLICATION

TripleGuard™ Insurance Associate

ADVICE. INSURANCE. INVESTMENTS.

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

Please complete all pertinent questions to avoid processing delays and return to: **CDSPI**, 2005 Sheppard Ave East, Suite 500, Toronto, ON M2J 5B4
Fax: 1.866.337.3389

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.

Membership Requirements For New Coverage : Dentists must be members of the CDA or a participating provincial or territorial association to be eligible to apply.

Membership Requirements for Existing Coverage: If you are increasing coverage or making a change to an existing policy, there are no membership eligibility requirements.

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: ⌊ | | | | | ⌋

7. B. Payment Frequency (*Choose One*):

- ☐ Same as current
  (Only applies if you are an existing client paying premiums)
- ☐ Annual
- ☐ Quarterly*
- ☐ Monthly*
  (If paying monthly, you must select Automatic Payments under the Payment Method section below)

*A 2.23% processing charge applies to monthly and quarterly payments.

7. C. Payment Method (*Choose One*):

- ☐ Invoice (Will be mailed to your address on file for payment.)
- ☐ Automatic Payments
  - ☐ Pre-authorized Chequing Plan (PAC) -
    Please complete a Pre-Authorized Chequing Plan Form
  - ☐ VISA/MasterCard –
    CDSPI will contact you to obtain credit card details upon receipt of your application.

Section 2 Party To Be Insured

Membership Requirements: Dentists must be members of the CDA or a participating provincial or territorial association to be eligible to apply.

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. Individuals only: Provincial/CDA License Number (mandatory):

5. 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	Provincial/CDA License Number
	☐ Member of Provincial/Territorial Dental Association* ☐ Member of CDA ☐ Non-member			
	☐ Member of Provincial/Territorial Dental Association* ☐ Member of CDA ☐ Non-member			
	☐ Member of Provincial/Territorial Dental Association* ☐ Member of CDA ☐ Non-member			

** 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 ($50,000 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. **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)**

4. Extensions:
To increase this coverage, indicate below the additional amounts applied for:
Condominium Contingent
($100,000 automatically included - maximum $500,000 total coverage)
Choose total amount of coverage:
☐ $125,000 (total coverage)
☐ $150,000 (total coverage)
☐ $175,000 (total coverage)
☐ $200,000 (total coverage)
☐ $500,000 (total coverage)

Section 3 TripleGuard™ Insurance Associate Package (continued)

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

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

By submitting personal information, including, but not limited to, name, address, date of birth, and medical information, to Zurich Insurance Company Ltd and its affiliates (collectively, "Zurich") and authorized representatives respecting individuals insured or covered by this policy, you acknowledge and confirm that you have consented to or, if applicable, you have obtained, and are retaining the consent of such individuals to the collection, storage, use and disclosure of their personal information for the purposes of securing and administering such insurance coverage(s). Personal information is processed and stored by Zurich and its affiliates and authorized representatives in both domestic and foreign jurisdictions. Please contact the Zurich Privacy Officer if you require further additional information regarding the collection, use, disclosure, processing and storage of your personal information via email at privacy.zurich.canada@zurich.com or you can review our privacy statement at https://www.zurichcanada.com/en-ca/about-zurich/privacy-statement. The policyholder may refuse to consent or withdraw their consent to the collection, storage, use or disclosure of personal information; however, the refusal to provide consent may result in Zurich being unable to offer and administer insurance coverage or prevent Zurich from being able to pay claim benefits. Zurich is committed to protecting the privacy and confidentiality of information provided. Your file is secured in our offices or those of our administrator or agent. You may request to review your personal information and make corrections by writing to: Privacy Officer, Zurich Insurance Company Ltd (Canadian Branch), 100 King Street West, Suite 5500, P.O. Box 290, Toronto, ON M5X 1C9.

CDSPI and CDSPI Advisory Services Inc. collect, use and disclose your personal information on this application for purposes that include: determining your eligibility for our plans; administering and providing insurance and financial services to you; underwriting; claims adjudication; protecting against fraud, errors or misrepresentations; meeting legal, regulatory or contractual requirements; marketing and to advise you of other related products and services. We limit access to your personal information in our files to our employees, authorized agents and third-party service providers, and to any other person you authorize or as authorized by law. These people, organizations and service providers may be in countries outside Canada, so your personal information may be subject to the laws of those countries. You may request to review the personal information your file contains and make corrections by sending a written request to: CDSPI, Attn: The Chief Privacy Officer, 2005 Sheppard Ave East, Suite 500, Toronto, ON M2J 5B4. To find out more about our privacy practices, visit www.cdspi.com/privacy.

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 Zurich Insurance Company Ltd. for the insurance indicated above. The information provided by me is true and complete and Zurich Insurance Company Ltd. may rely on it in issuing insurance coverage to me. I acknowledge receipt of and confirm my agreement with the Privacy Statement. A photocopy or facsimile of this authorization shall be as valid as the original.

_____ Date: Day Month Year

Signature