APPLICATION

TripleGuard™ Insurance Associate

CDSPI 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

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 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:

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

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. **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. 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.

5. 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

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.

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.