APPLICATION

TripleGuard™ Insurance Practice Owner

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. Associates are not covered by the practice owner's TripleGuard™ insurance. If you are an associate, 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.

COVERAGE APPLIED FOR

Section 3 TripleGuard™ Insurance

TripleGuard™ Insurance includes:
Office contents coverage (up to the amount that you applied for), practice interruption coverage based on your actual loss sustained, and $5-million of commercial general liability coverage.

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

Street and Number Suite No.

City/Town Province Postal Code

2. Is the location to be insured (*check one*)**:**
☐ Your only office, or
☐ An additional office (i.e. 2nd, 3rd, etc.)

3. Is this application for insurance at the stated location for (*check one*)**:**
☐ New coverage at this location, or
☐ An increase to existing coverage at this location

4. Amount of office contents coverage applied for at this time (must be a multiple of $5,000, minimum $50,000):

$ _____
(do not include existing coverage)

5. Effective date of coverage: Day Month Year

6. Do you plan to do extensive renovations in the near future?
☐ Yes ☐ No
If "Yes", please contact CDSPI Advisory Services Inc. to discuss.

7. Do you own your building? ☐ Yes ☐ No
If "Yes", renewal date for building insurance coverage:

Day Month Year

8. Building Category (*check one*):
☐ Fire-Resistive and Non-Combustible: Any building constructed entirely of non-combustible materials, e.g. steel
☐ All other construction: A frame building, a masonry building with brick or concrete walls and wood-joist roof or wood in any floors, or any other type of building constructed with any combustible materials

Note: The $1,000 deductible for office contents claims under the TripleGuard™ Insurance plan is waived for claims in excess of $5,000. However, this "pay no deductible" feature does not apply to participants who have made three or more claims in the past three years and who are assigned a deductible of $2,500. Independent of the deductible you have for other types of losses, in the event of loss or damage caused by earthquake, you pay a deductible (see below) for office contents and practice interruption claims that is a percentage of the total amount of your office contents coverage as shown on your Memorandum of Insurance.

British Columbia earthquake zones (Cresta zones 1-4): If the coverage limit is $500,000 or less, the deductible for an earthquake claim is 10 percent of the coverage limit. If the coverage limit is over $500,000, the deductible is 10% of the coverage limit, subject to a minimum deductible of $100,000.

Quebec and the rest of British Columbia (excluding Cresta zones 1-4): If the coverage limit is $500,000 or less, the deductible for an earthquake claim is 5 percent of the coverage limit. If the coverage limit is over $500,000, the deductible is 5 percent of the coverage limit, subject to a minimum deductible of $100,000.

The rest of Canada (excluding British Columbia and Quebec): If the coverage limit is $500,000 or less, the deductible for an earthquake claim is 5 percent of the coverage limit. If the coverage limit is over $500,000, the deductible is 5 percent of the coverage limit, subject to a minimum deductible of $50,000.

9. Extensions:
To increase this coverage, indicate below the additional amounts applied for:

Valuable Papers $ _____
($50,000 automatically included)

Accounts Receivable $ _____
($50,000 automatically included)

Money and Securities $ _____
($15,000 automatically included – maximum $25,000 total coverage)

Employee Dishonesty $ _____
($25,000 automatically included – maximum $150,000 total coverage)

10. **Do you want Equipment Breakdown coverage?** For an additional premium, this option insures mechanical or electrical equipment 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. If equipment breakdown results in loss of income, an eight hour waiting period applies.

☐ **(check if desired)**

11.A. 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.

B. Are you required to provide notice of cancellation* of this insurance to your landlord? ☐ Yes ☐ No

C. If you answered "Yes" in 12B, indicate the number of days notice required: ☐ 15 days OR ☐ 30 days

* When cancellation of coverage is requested and if notice of cancellation is required, your coverage will be cancelled at the end of the notice period selected in 12C, unless release letters are provided from the applicable additional insured(s). CDSPI will endeavour to mail the certificate holder written notice of cancellation according to the notice period selected.

12. 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.

*Continued – **signature required** on back page.* ▶

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.*

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.