Insured by Partners Indemnity Insurance Brokers Ltd. Established 1923

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Insured by Continental Casualty Company

Office/Clinic Business Insurance Application - Option F

Full Name of Clinic: _____

Individual ☐ Partnership ☐ Corporation ☐

Address _____

Mailing Address, if different from above _____

Email Address: Primary: _____ Secondary: _____

Web Site :_____

Owner/Contact Person : _____ Phone No: _____

Description of operation :_____

Years established in Business : _____

Effective Date of Coverage : _____ Policy Number : _____

Name of present Insurer : _____

Has an Insurer ever rejected or cancelled any insurance? ☐ No ☐ yes, provide details

_____

_____

Coverage Requested

CGL	New	☐	Renewal	☐
Crime	New	☐	Renewal	☐
Property	New	☐	Renewal	☐

Gross Annual Revenues : $ _____

No. of Employees: ____

Full time : _____

Part time : _____

List any and all losses over past five (5) years (Coverage, Date, Amount, Description)

_____

_____

_____

Do you own control or operate any subsidiary or affiliated Organizations other than the one listed above? If yes, please provide name of Organization, relationship and nature of business operations

_____

_____

Commercial General Liability Insurance

Limit of Liability Requested

$ 2,000,000 ☐
$ 3,000,000 ☐
$ 5,000,000 ☐

- Higher limits are available on request.

Crime: including Employee Dishonesty

Limit Requested

$ 25,000 ☐
$ 50,000 ☐
$ 100,000 ☐

No. of Class 1 Employees (Class 1 employees include management positions and other employees who have access to money, securities, and/or other property (i.e. book-keepers) _____

Do employees who reconcile the monthly bank statements also either:

- o sign cheques ☐ Yes ☐ No
- o handle deposits ☐ Yes ☐ No
- o have access to signing machines, signature plates or corporate seal ☐ Yes ☐ No

Property: Insurance

Provide breakdown of Property Limit Requested: Replacement Value

- o Building (**Must refer to Partners Indemnity to quote**) $_____
- o Office Contents Furniture & Equipment $_____
- o Tenants leasehold Improvements $_____
- o Dispensary $_____
- o EDP Equipment, Media & Software $_____
- o Portable computers $_____
- o **Total** **$** 0.00

- **Please complete the attached Business Income Work Sheet if your net profit plus fixed expenses exceed $150,000.**

_____
_____

If building coverage is required, please provide the following:

- o Year constructed (If greater than 40 years, please provide the year building last updated)

_____
_____
_____

- o Type of construction: ☐ Wood Frame ☐ Steel on Steel ☐ Solid Masonry
- o Fire Protection: ☐ Hydrant ☐ Fire Station within 8 km. ☐ Unprotected
- o Security System: ☐ Fire ☐ Burglary ☐ Local ☐ Central Alarm Protection
- o Number of stories: _____
- o Surrounding exposures: (i.e. neighbouring properties)?

_____
_____

- o Location address: (if different from Address listed)

_____
_____

DECLARATION AND SIGNATURE

The undersigned declares that to the best of his or her knowledge and believe the statements and information in this application statement are true. The Company is hereby authorized to make any investigation and inquiry in connection with the application statement that it deems necessary.

Although the signing of this Application form does not bind the Applicant to purchase the insurance, the undersigned Applicant agrees that this form and the information provided shall be the basis of the contract should a policy be issued and this form will become part of the policy.

_____

Name of Applicant (please print)

Title: _____

_____ _____

Signature of Applicant: (*First Named Insured)*

Date

If you have questions
Telephone 416-366-5243 or Toll Free 1-877-427-8683
FAX: 1-416-862-2416 or email: cand@partnersindemnity.com

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