AmRisk Insurance & Financial Services

AmRisk Insurance & Financial Services
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BUSINESS OWNERS POLICY (BOP) APPLICATION

Your Name | Date

Company Name

Address

City | State (or Province) | Country | ZIP

Phone Number ( ) | Fax Number ( ) | Email

For internal use only. Email address will never be sold or shared.

Date new coverage needs to be effective ___/___/___

DESCRIBE YOUR BUSINESS

Legal Entity ❍ **Corporation** ❍ **Limited Liability Company** ❍ **Partnership** ❍ **Individual** ❍ **Other** _____

Please provide a complete description of your business _____

Annual Sales/Receipts $ _____ Year Business Purchased/Began _____ Federal Employer ID Number _____ (If applicable)

Are there any other businesses that are owned or operated by you that are not to be covered by this policy? ❍ **Yes** ❍ **No** If Yes, please describe on seperate page.

Number of employees _____ Full-time: _____ Part-time: _____

PROPERTY AND COVERAGE INFORMATION

Please tell us about each of your locations.
(Copy this section and complete for each additional location, use as many pages as needed.)

How many stories? _____ Location Number: _____ of _____

Location Address: Same as the company address: ❍ **Yes** ❍ **No**
If **No**, please enter the building address:

Street: _____

City: _____ County: _____ State: _____ Zip: _____

Square Feet Occupied: _____ sq. ft. What year was the building built? _____

If older than 20 years, please enter the year any updates were made to the building:
Re-wired _____ Re-roofed _____ Re-plumbed _____ HVAC _____

Approx. total building sq. ft.: _____

Are there other businesses in the same building? ❍ **Yes** ❍ **No**
If **Yes**, please provide a complete description of the other businesses.

Please check the type of building construction (check only one): ❍ **Frame**
❍ **Joisted Masonry** ❍ **Non-Combustible** ❍ **Masonry Non-Combustible** ❍ **Fire Resistive**

Is your building 100% sprinklered? ❍ **Yes** ❍ **No**

COVERAGE REQUESTED

General Liability Limits: ❍ **1M/2M** ❍ **2M/4M**

For this building, are you the: ❍ **Owner** ❍ **Tenant**
❍ **Deductible:** (check only one) ❍ $500 ❍ $1,000 ❍ $2,500 ❍ $5,000

Building Replacement Cost at 100%: (if owned) $ _____

Tenant's Improvements and Betterment: $ _____

Business Contents:
(Indicate the cost to replace with new equipment in the event of a total loss)

- Radiograph Equipment: $ _____
- Orthodontia Operatories: (furniture, equipment, instruments) $ _____
  - *Number Of Chairs:* _____
- All Other Orthodontia Equipment: $ _____
- Laboratory Equipment: $ _____
- Office/Waiting Room Furniture: $ _____
- Anesthesia Related Equipment: $ _____

Other (please describe): _____ $ _____

TOTAL BUSINESS CONTENTS: **$** _____

ADDITIONAL INTERESTS (MORTGAGE, LOSS, PAYEE, ADDITIONAL INSUREDS)

Name: _____

Address: _____

Relationship With Insured: _____

If you have any questions please call 800.874-9191

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UMBRELLA LIABILITY

This coverage provides your firm additional liability protection.

Please choose one coverage amount: ❍ **$1M** ❍ **$2M** ❍ **Greater than $2M** ❍ **Do not quote umbrella**

Desired Effective Date: ___/___/___

EMPLOYMENT RETIREMENT INCOME SECURITY ACT (ERISA)

Do you have a retirement plan for your employees? ❍ **Yes** ❍ **No**

Welfare & Retirement Fund Coverage (ERISA): $ _____ Bond limit (limit equal to 10% of fund balance)

Official Name Of Retirement Plan: _____

Desired Effective Date: ___/___/___

COMMERCIAL AUTO

Does the insured have a commercial auto policy in force? ❍ **Yes** ❍ **No** What is the maximum radius of operation?

If **No**, do any employees use their personal autos or hired/rental vehicles for part of their job responsibilities? ❍ **Yes** ❍ **No**

If **Yes**, select all that apply. Driving involves: ❍ **Time constraints** ❍ **Delivery** ❍ **Student or youth transportation** ❍ **Outside sales** ❍ **Routine errands** ❍ **Other**

How many of the employees regularly using their personal autos are < = 25 years of age?

Indicate the control measures in place: (select all that apply)

❍ **Employees carry personal auto insurance liability of at least 100/300/50 ($100,00/$300,000/$50,000 split) or $300,000 CSL (Combined Single Limit)**

❍ **Written guidelines requiring minimum age and driving experience before allowing use of personal vehicles in the course of the business**

❍ **Drivers' MRVs are on file and checked anually to be insured** ❍ **Other** ❍ **No control measure in place**

CLAIMS INFORMATION:

Within the past five years have you had any claims on any line of coverage for which you are applying? ❍ **Yes** ❍ **No**

(If Yes, please attach a separate page with claim detail, payment amount, and status of the claim.)

APPLICATION FRAUD WARNING

Any person who knowingly and with the intent to defraud any insurance company or another person files an application containing materially false information, or conceals for the purpose of misleading, information concerning any fact material there to, commits a fraudulent insurance act, which is a crime and subjects the person to criminal and (NY: substantial) civil penalties.

Duty of Disclosure: In addition to providing all basic information necessary to enable us to place the risk, you must ensure that you are complying with your legal duty of disclosure of all material matters relating to the risk. In particular, you must satisfy yourself as to the accuracy and completeness of the information you provide the insurers. In this respect, you must provide all information relating to the risk whether favorable or not, which would influence the judgment of prudent insurer in determining whether they will take the risk, and, if so, for what premium and on what terms. If all such information is not disclosed by you, insurers have the right to void the contract from its commencement, which may lead to claims not being met.

Signature | Date

PLEASE SIGN AND DATE IN INK