



The Professional Protector Plan® Property Supplement



Name: (First/Middle Initial/Last/Designation) _____	Policy Number _____	Desired Effective Date / /
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PROPERTY INFORMATION (Please complete a separate property supplement for each practice location.)

1. Practice Address:								
Street _____			City _____		County _____		State _____	Zip Code _____
2. Describe the building in which you are located:								
Construction of Building you occupy	No. of Stories	Floor on Which You Are Located	Year Built	Total Sq. Footage of Building	Square Footage of Your Office	Square Footage of Basement(s)	Basement(s) Finished	<u>Agent Use Only</u> Protection Class
							<input type="checkbox"/> YES <input type="checkbox"/> NO	
3. Year building updated (if over 25 years of age) _____:								
Year Roof Updated _____ Electric Meets Building Codes _____ Yes _____ No Plumbing is maintained to prevent exposure to leaking or frozen pipes _____ Yes _____ No Building was built for a different occupancy and has been modified _____ Yes _____ No If Yes, please describe: _____								
4. Is your practice location equipped with any of the following systems?								
						YES		NO
						<u>Local</u>	<u>Central Station</u>	
a. Sprinkler.....						0	0	0
b. Fire alarm.....						0	0	0
c. Smoke detectors.....						0	0	0
d. Burglar alarm.....						0	0	0
5. Is your practice located in your residence?0 Yes 0 No								
If "Yes," does your office have a separate entrance?0 Yes 0 No								
6. What is your practice location's distance to the nearest fire station?.....miles								
7. Do you utilize a watchman service?.....0 Yes 0 No								
8. Are cash and checks deposited daily?.....0 Yes 0 No								
9. How do you store your cash on hand, prescription drugs, precious metals?								
<input type="checkbox"/> Safe <input type="checkbox"/> Fire Resistive Container <input type="checkbox"/> Other (describe) _____								
a. Amount of cash left on premises overnight						\$	_____	
b. Value of drugs.....						\$	_____	
c. Value of metals						\$	_____	
d. Value of other (describe) _____						\$	_____	
10. How do you store your accounts receivable records? _____								
11. Do you maintain duplicate accounts receivable records?0 Yes 0 No								
12. Are accounts receivable duplicates kept off your premises?0 Yes 0 No								

DESCRIPTION OF CONTENTS

13. Are you within 1 mile of an ocean, gulf or river? <input type="checkbox"/> Yes <input type="checkbox"/> No				
14. Are you less than 10 feet above sea level? <input type="checkbox"/> Yes <input type="checkbox"/> No				
15. Total number of operatories: Fully equipped:_____ Partially equipped:_____ Bays:_____				
16. Name and address of Loss Payee or Lessor on contents (i.e., office and dental equipment):				
Name	Street	City	State	Zip Code
Name	Street	City	State	Zip Code
17. Which coverage do you prefer? <input type="checkbox"/> PPP Standard <input type="checkbox"/> PPP Gold (Please contact your agent for information on this valuable coverage)				
Estimate the total cost to replace Dental Practice Personal Property:				
		PPP Standard	<u>Amount of Coverage Desired</u>	
A. Practice Contents:.....				
1. Furniture and fixtures.....			+ _____	
2. Operatory equipment.....			+ _____	
3. Instruments and supplies.....			+ _____	
4. Improvements and betterments.....			+ _____	
5. Glass.....			+ _____	
6. Other _____			+ _____	
Practice Contents Subtotal (100% Replacement cost).....			\$ _____	
B. Practice Records/Charts, Account Receivables, valuable Papers, X-Rays:		\$25,000 minimum	+ _____	
C. Dental Practice Blanket Limit Total (A + B)			+ _____	
D. Signs not attached to building.....		\$10,000.....	+ _____	
18. Inflation Guard – Dental Practice Personal Property.....		Optional.....	_____ %	
(May select quarterly increase from 1% - 5%)			Quarterly	
19. Valued Practice Income.....			\$ _____ / _____	
		Minimum daily limit of \$300 / 32.5 days	Daily Limit / # days	
20. Employee Dishonesty:				
a. money/securities.....		\$10,000.....	\$ _____	
b. welfare and pension plans.....		\$15,000.....	\$ _____	
21. Rents (annual rental income).....		Optional.....	\$ _____	
22. Dentist's Electronic Equipment (including Electronic Data Processing equipment).....		\$25,000.....	\$ _____	
Do you use surge protection devices? <input type="checkbox"/> Yes <input type="checkbox"/> No				
23. Equipment Breakdown Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No				
<input type="checkbox"/> Dental Equipment only				
<input type="checkbox"/> Dental Equipment and Heating, Ventilation & Air Conditioning Equipment				
Do you own the building in which your office is located? <input type="checkbox"/> Yes <input type="checkbox"/> No				
24. Fine Arts (attach appraisals, if additional coverage is desired).....		\$10,000 subject to maximum \$1,000 per item	\$ _____	
25. Have you had any coverage declined or property losses (fire, burglary, water damage, premises, earthquake, etc.) or employee dishonesty losses during the past three (3) years?..... <input type="checkbox"/> Yes <input type="checkbox"/> No				
If "Yes", please give details (cause of loss, amount paid, date of loss) on a separate sheet of paper.				
26. Property Deductible - \$250 (Optional Deductibles of \$500, \$1,000, \$2,500, \$5,000 and \$10,000 available (Please contact your agent)			\$ _____	

BUILDING INFORMATION - Complete only if you desire insurance on the building through this plan.

27. Building --- (Current Cost to Replace).....		\$ _____
a. additional buildings on premises (garage, storage building).....		\$ _____
b. inflation guard (may select quarterly increase from 1% - 5%) Mandatory		_____ % Quarterly
28. Please indicate % of vacancy, or tenants by type of business and/or operations conducted, and square footage for each:		
	Sq. feet:	
	Sq. feet:	
29. Is your building located on a known land subsidence area?..... <input type="checkbox"/> Yes <input type="checkbox"/> No		
30. Is your building resting on a saturated man-made (filled ground) or alluvial (soft) soil? <input type="checkbox"/> Yes <input type="checkbox"/> No		
31. Name of building owner: _____		
32. Name and address of Mortgagee:		
Name	Street	City
State	Zip Code	
Name	Street	City
State	Zip Code	
33. Describe the occupant to the right of your building, including distance.	Describe the occupant to the left of your building, including distance.	Describe the occupant to the rear of your building, including distance.

I hereby acknowledge that the aforementioned statements and answers are correct and complete. I further understand that any incorrect or incomplete statement could void my protection. I hereby authorize the CNA Insurance Companies to release the information on this application and associated underwriting information.

FRAUD NOTICE – WHERE APPLICABLE UNDER THE LAW OF YOUR STATE

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false or incomplete information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES (for New York residents only: and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.) (For Pennsylvania Residents only: Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete or misleading information shall, upon conviction, be subject to imprisonment for up to seven year and payment of a fine of up to \$15,000.) (For Tennessee Residents only: Penalties include imprisonment, fines and denial of insurance benefits.)

Signature in full: _____

Date _____