

BUSINESS PACKAGE APPLICATION

Name of Applicant (First Last ex: John Doe):

Business Name:

Mailing Address:

City:

Prov./Terr.:

Postal Code:

Telephone:

Email:

Business Address (if different from above):

City:

Prov./Terr.:

Postal Code:

Telephone:

Email:

Membership Information

In order to be eligible for this insurance policy, you must be a member of the Canadian Association of Optometrists (CAO). If you are not a member, this policy is null and void.

Please confirm you understand and agree to the eligibility requirements

Are you a member in good standing with the Canadian Association of Optometrists? Yes No

Please indicate to which Provincial Association you are a member of

- | | |
|--|--|
| <input type="checkbox"/> Alberta Association of Optometrists | <input type="checkbox"/> Newfoundland & Labrador Association of Optometrists |
| <input type="checkbox"/> BC Doctors of Optometry | <input type="checkbox"/> Nova Scotia Association of Optometrists |
| <input type="checkbox"/> Manitoba Association of Optometrists | <input type="checkbox"/> Prince Edward Island Association of Optometrists |
| <input type="checkbox"/> New Brunswick Association of Optometrists | <input type="checkbox"/> Saskatchewan Association of Optometrists |

Applicant Details

Do you/your business provide professional services outside the scope of Optometry? Yes No
If yes, please provide the name, discipline and confirmation that the individual(s) has/have insurance:

Has any application for commercial general liability and/or property insurance ever been denied or cancelled? Yes No
If yes, please provide details.

Have you/your business ever sustained a commercial general liability and/or property loss or has such a claim been made against you/your business? Yes No
If yes, please provide details.

Coverage Details

\$50,000 Contents on premises (equipment, stock, improvements & betterments)

\$2,000,000 Commercial General Liability

\$10,000 Crime (Employee Fidelity)

\$1,000 Deductible

Premium: \$1,500

Increased Contents

If more than \$50,000 of contents coverage for the package is required, the following increased limits are available

Limit	Cost	Option Selected
\$100,000 Contents	\$195 additional premium	<input type="checkbox"/>
\$150,000 Contents	\$390 additional premium	<input type="checkbox"/>
\$200,000 Contents	\$585 additional premium	<input type="checkbox"/>
\$250,000 Contents	\$780 additional premium	<input type="checkbox"/>

Are the coverages above adequate? Yes No
If no, please provide the details of your requirements.

Increased Commercial General Liability

Yes No

Do you require increased Commercial General Liability?

Limit	Cost	Option Selected
Increase from \$2,000,000 to \$5,000,000	\$200 additional premium	<input type="checkbox"/>

Additional Location

Do you have any additional locations that require insurance?

Limit	Cost	Option Selected
\$50,000 Contents	\$880 annual premium	<input type="checkbox"/>
\$100,000 Contents	\$1,075 annual premium	<input type="checkbox"/>
\$150,000 Contents	\$1,270 annual premium	<input type="checkbox"/>
\$200,000 Contents	\$1,465 annual premium	<input type="checkbox"/>

Please provide the address for the additional location:

Business/Corporation Name:

Location Address:

City:

Province/Territory:

Postal Code:

Telephone:

Do you require coverage for more than one additional location?

Yes No

Building / Condominium Unit Coverage

Do you own the building/condominium unit where your clinic is located and require building coverage?

Yes No

Co-Insurance

Since the concept of co-insurance is fundamental principle of property and business continuation insurance, it is imperative that you understand it before considering the amount of insurance you buy. Co-insurance is simply an agreement between 'You' and the 'Insurance Company', whereby you agree to maintain coverage up to a stated percentage of the value of the property you wish to insure (**this policy has a 90% co-insurance clause**). Should a loss occur, consideration is then given to the amount of insurance carried compared to actual values prior to the loss. If the amount of insurance is within the agreed co-insurance percentage requirement, the loss is paid in full, up to the

policy limits. If, however, the amount of insurance that you carry is below the agreed percentage, you and the company will then share in the loss.

Please note the following example:

Assume that the replacement cost value of your contents is \$100,000, and the policy contains a 90% coinsurance clause. This means you should be insuring to at least 90% of the replacement cost value of your contents – or \$90,000 in this case.

If you are only carrying \$80,000 of coverage, and suffer a partial loss of \$50,000 (replacement cost value), then the Insurer will indemnify you based on the amount that you have insured to required value, according to the following formula:

$(\text{Amount of Coverage Insured} \div \text{Required Amount of Coverage Insured}) \times \text{Amount of Loss} = \text{Claim Payment}$

$(\$80,000 \div (\$100,000 \times 90\%)) \times \$50,000 = \$44,444$ Payment for loss (less deductible)

As you can see, in this example the Insurer will only indemnify you for the portion of the loss that you are insured to the required replacement cost value.

*All losses are subject to a deductible, which is deducted from the payment amount.

BMS recommends that your insurable values be reviewed frequently by a competent, independent appraisal company.

Please indicate any additional insured(s) to be listed on your certificate:

Name:

Address:

City:

Province/Territory:

Postal Code:

Please indicate any loss payee(s) to be listed on your certificate:

Name:

Address:

City:

Province/Territory:

Postal Code:

Declarations and Warranty

The undersigned declares:

I declare that during the last five years no insurer has cancelled, declined or refused to issue me/us any form of liability insurance and that this application discloses the hazards known to exist at the date of this application.

I declare that the statements herein are in every respect true and correct and hereby apply for a contract of insurance to be based upon the truth of the said statements.

Submitting this form does not bind the Applicant or company to complete the insurance but is agreed that this form shall be the basis of the contract should a policy be issued.

The insurance premium is fully retained and not refundable.

I declare that I am a member in good standing with The Canadian Association of Optometrists. If it is determined that I do not hold an active membership, I understand that my insurance policy is null and void.

Signed by:

Position:

Date:

Payment Information

The following provinces are subject to provincial sales tax:

Ontario residents add 8% sales tax
Québec residents add 9% sales tax
Manitoba residents add 7% sales tax
Newfoundland residents add 15% sales tax
Saskatchewan residents add 6% sales tax

Sub-total \$

Tax \$

Total Enclosed \$

All other provinces are exempt.
GST is not applicable to insurance premiums.

All cheques payable to BMS Canada Risk Services Ltd, or complete credit card authorization below.

Authorization for Credit Card Charge

VISA, AMEX or M/C Account No:

Expiry Date:

CVV:

Cardholder Name:

Signature:

BMS Canada Risk Services Ltd. (BMS Group)
825 Exhibition Way, Suite 209
Ottawa, ON K1S 5J3

Toll Free: 1-844-517-1371
Fax: 613-701-4234
Email: cao.insurance@bmsgroup.com