California Optometric Association Sponsored

Business Owners Package Application

How to request a quote or apply: complete this form, select the coverages you desire, and email to LH.Admin@getamba.com or mail to AMBA, P.O. Box 5256, Des Moines, IA 50306. Please print or type all information. If you would like assistance completing the form, call **800-775-2020.**

1.) GENERAL APPLICANT INFORMATION

300671w

Requested Effective Date:_____ Membership: ☐ COA Member ☐ Non-Member

Named Insured is: ☐ Individual ☐ Corporation ☐ Partnership ☐ Joint Venture ☐ Other _____

Named Insured is: ☐ Self Employed ☐ Employee Optometrist ☐ Independent Contractor ☐ First Year Graduate_____ (Date Graduated)

If you are an Employee Optometrist, list name of employer_____

Business/Corporate Name, DBA, or Your Name, if not incorporated | Federal Tax I.D. # or Social Security #

Name of Owners, Partners, and Corporate Officers who are active in the business, their professional occupation and their social security numbers.

Street Address | Daytime Phone | Fax Number

City | County | State | Zip Code

E-Mail Address

Location Address, if other than above: Please list additional locations on a separate sheet and attach.

Street Address

City | County | State | Zip Code

Interest In Premises:
- ☐ Lessee
- ☐ Owner/Occupant
- ☐ Owner/Lessor
- ☐ Condo Owner

2.) BUSINESS OWNERS PACKAGE

Indicate limits of coverage you require in addition to the limits or coverages indicated below, for each location:

PROPERTY COVERAGES	LIABILITY COVERAGES
Includes Business Income/Extra Expense — Actual Loss Sustained —	A separate policy must be issued for Professional Liability for the selected limits of liability.

Coverage A
Building
$_____
Replacement Cost

Coverage B
Contents
$_____
Replacement Cost

Deductible Per Policy:
☐ $500 ☐ $1000 ☐ $2500 ☐ $5000

Includes:

Accounts Receivable . . . . . $25,000 or $_____

Business Income – Up to 12 Months

Valuable Papers . . . . . $25,000 or $_____

Personal Property Off Premises . . . . . $2,500 or $_____

Optional:

☐ Computers and Media . . . . . $10,000 or $_____

Coverage C — Business Liability Limits of Insurance
☑ $2,000,000 per occurrence / $4,000,000 annual aggregate

Coverage D — Medical Payments $10,000 Per Person (included)

Annual Receipts:_____

Includes:

Fire Legal Liability

Tenant Glass Coverage – Up to $25,000

Optional:

☐ Tenant's Legal Liability (all perils)

☐ Employee Dishonesty

☐ Employee Benefits Liability $10,000 or . . . .$_____

☐ Full Glass Coverage (Linear Feet) . . . . . ._____ft.

☐ Hired and Non-Owned Auto.....☐ Yes....☐ No

☐ Sewer and Drains

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Additional Insureds:

☐ Loss Payee ☐ Additional Named Insured

☐ Mortgagee ☐ Leased Equipment Lessor

(If more than one, please provide name(s) and address(es) on a memorandum.)

Name_____

Address _____

_____

_____

Has the Insured agreed to name anyone as an Additional Insured?

ie: Landlord? ☐ Yes ☐ No

Additional Insured's interest: _____

(If more than one, please provide name(s), address(es) and interest on a memorandum.)

Name_____

Address _____

_____

_____

Prior Carrier Information — Business Owners

Policy Term From/To	Insurance Company	Policy Number

Any policy or coverage declined, cancelled, non-renewed or placed in a non-standard market in the past 3 years? ☐ Yes ☐ No If yes, explain.

Loss Information (list all prior claims reported to carrier within 3 years — attach list if necessary)

Include Property and Liability. ☐ No prior losses in 3 years.

Loss Date	Description of Loss	$ Amount Paid	$ Reserve	Open	Closed

To the best of your knowledge are there any incurred but not reported claims? ☐ Yes ☐ No If yes, explain.

Complete This Section for Each Location

Construction:

☐ Frame
☐ Joisted Masonry
☐ Non-Combustible
☐ Masonry Non-Combustible
☐ Modified Fire-Resistive
☐ Fire-Resistive

Building Occupancy:

☐ Single
☐ Multiple
If multiple, list other occupants:_____
_____
_____

Is Building 75% Sprinklered?

☐ Yes
☐ No

Total Bldg. Area: _____Sq. Ft

Area Occupied by Insured: _____Sq. Ft.

Basement(s): _____

Building • Year Building Built _____ • Number of Stories _____

If building is more than 15 years old, have the wiring, plumbing and heating-A/C and/or roofing systems been partially or completely inspected, updated or replaced? ☐ Yes ☐ No If yes, provide the year updated or replaced:

Wiring:_____ Plumbing:_____ Heating:_____ Roof:_____ Comprehensive Renovation:_____

Note: Comprehensive Renovation Year reflects when the building was gutted to the exterior walls and completely rebuilt with new interior walls, plumbing, heating, wiring and roof.

Protection

- Number of fire extinguishers _____
- Smoke Detectors installed? . . . . . ☐ Yes ☐ No
  Hardwired? . . . . . ☐ Yes ☐ No
- Burglar alarm? . . . . . ☐ Yes ☐ No
  Type: ☐ local ☐ silent ☐ central station
- Fire alarm? . . . . . ☐ Yes ☐ No
  Type: ☐ local ☐ silent ☐ central station

Management

- Year this business started _____ Year
- Total number of employees: _____ Full Time
  _____ Part Time

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3.) PROVIDER CONTRACTS

- ☐ Vision Service Plan
- ☐ AVP
- ☐ Cole Vision
- ☐ Davis Vision
- ☐ Block Vision
- ☐ Medical Eye Services (MES)
- ☐ Other_____
- ☐ Other_____
- ☐ Other_____
- ☐ Other_____
- ☐ Other_____
- ☐ Other_____

4.) SIGNATURE

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

I authorize AMBA to collect, use and disclose loss run information from my former Business Owners Package insurance policies solely for the purpose of obtaining proposals on my behalf from the program insurers. They are authorized to release to prospective insurers the name of my current insurer, pricing and policy terms. They may also release to prospective insurers the results of other competitive bids in order to allow an insurer to submit an improved quote. I will advise AMBA in writing if I do not want any of the above information released.

Signature:_____ Date: _____

Association Member Benefits & Insurance Agency
P.O. Box 5256
Des Moines, IA 50306

CA Insurance License #0I96562

800-775-2020 • COA.Insurance.service@getamba.com • www.COAMemberInsurance.com

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5.) REMARKS