

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. _____ Interest In Premises:

Street Address _____ Lessee

City _____ County _____ State _____ Zip Code _____ 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.		
<table style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> <p>Coverage A Building \$ _____ Replacement Cost</p> </td> <td style="width: 50%; vertical-align: top;"> <p>Coverage B Contents \$ _____ Replacement Cost</p> </td> </tr> </table> <p>Deductible Per Policy: <input type="checkbox"/> \$500 <input type="checkbox"/> \$1000 <input type="checkbox"/> \$2500 <input type="checkbox"/> \$5000</p> <p>Includes: Accounts Receivable \$25,000 or \$ _____ Business Income – Up to 12 Months Valuable Papers \$25,000 or \$ _____ Personal Property Off Premises \$2,500 or \$ _____</p> <p>Optional: <input type="checkbox"/> Computers and Media \$10,000 or \$ _____</p>	<p>Coverage A Building \$ _____ Replacement Cost</p>	<p>Coverage B Contents \$ _____ Replacement Cost</p>	<p>Coverage C — Business Liability Limits of Insurance <input checked="" type="checkbox"/> \$2,000,000 per occurrence / \$4,000,000 annual aggregate</p> <p>Coverage D — Medical Payments \$10,000 Per Person (included)</p> <p>Annual Receipts: _____</p> <p>Includes: Fire Legal Liability Tenant Glass Coverage – Up to \$25,000</p> <p>Optional: <input type="checkbox"/> Tenant’s Legal Liability (all perils) <input type="checkbox"/> Employee Dishonesty <input type="checkbox"/> Employee Benefits Liability \$10,000 or ... \$ _____ <input type="checkbox"/> Full Glass Coverage (Linear Feet) _____ ft. <input type="checkbox"/> Hired and Non-Owned Auto..... <input type="checkbox"/> Yes... <input type="checkbox"/> No <input type="checkbox"/> Sewer and Drains</p>
<p>Coverage A Building \$ _____ Replacement Cost</p>	<p>Coverage B Contents \$ _____ Replacement Cost</p>		

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

3.) PROVIDER CONTRACTS

- | | |
|---|--------------------------------------|
| <input type="checkbox"/> Vision Service Plan | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> AVP | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Cole Vision | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Davis Vision | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Block Vision | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Medical Eye Services (MES) | <input type="checkbox"/> 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 #0196562

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

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Remarks section on page 4

