



VIP Veterinary Insurance Program

General Information

Named Insured: _____ Policy No: _____

Mailing Address: _____ Phone: _____

Email Address: _____ Website: _____

Estimated annual revenue for coming year: _____

Maximum number of DVMs working at any one time: _____

Total number of Employees: _____

List current DVM's: _____ Indicate % of time spent on the applicable category

DVM Names	{O}wner {E}mployee {L}ocum	Small Animals	Large Animal (200+ lbs)	Equine + Exotics	Herds, Ranch, + Flocks (20+)	Other Services

Detailed list of business operations:

Please list any claims or losses in the last five years:

Are you aware of any unreported claims over the last year: YES NO



Other Services Provided:

% of Gross Revenue

- Grooming Facilities? _____
- Pet Training? _____
- Retail Pet Supplies? _____
- Boarding or Kennels? _____
- Crematorium? _____
- Meat Inspections? _____
- Pet Cemetery? _____
- Embryo Work? _____
- Any Professional Services Outside of Canada? _____
- Any Non DVM Chiropractor Dentist Acupuncturist? _____
- Entertainment, Wild or Exotic Animals?
(Not native to North America) _____

Owned by Clinic? YES NO

Total Value of all animals: \$ _____

If Yes, Attach Government Requirements

of tanks: _____
Values including transit: \$ _____

Maximum value of animal: \$ _____

Large Animals over 200lbs

- Do you treat large herds? YES NO
- Average size of each herd: (No of heads) _____
- 'Maximum' size of each herd (# head): _____
- Number of Herds you treat: _____
- Describe all services including consulting: _____

Type of animal: Goats: YES NO
Sheep: YES NO
Cattle: YES NO

Do you treat animals at your clinic? YES NO

Equine & Exotics

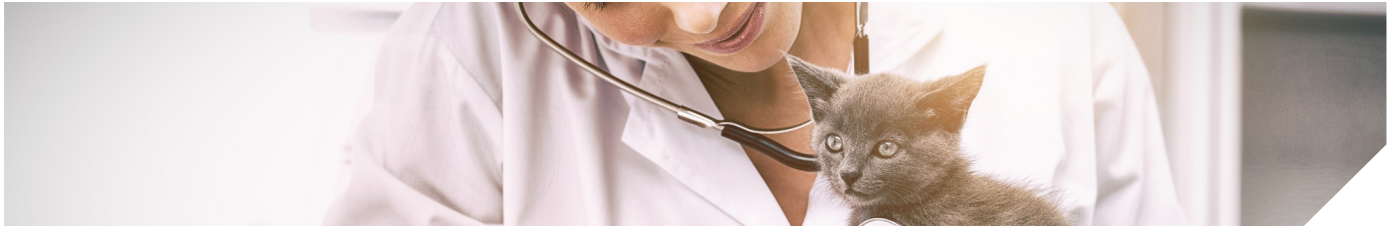
- Do you treat Thoroughbreds? YES NO
- Average value of animal: \$ _____
- Pre-sale examinations: YES NO
- Race track operations: YES NO

Maximum value of animal: \$ _____
Name of race track(s): _____
Name of race track(s): _____

Location No 1

- Construction Type: _____
- Are you the only occupant in building? YES NO
- Other Occupants: _____
- Your Square Footage: _____
- Do you own or rent? OWN RENT

Number of Stories: _____
Year Built: _____
Total Building Square Footage: _____



Air Conditioning: None Central Window Unit
 Alarm Protection: Monitored Fire Alarm Monitored Burglar Alarm
 Fire Protection: Hydrants within 500 ft. Fire Hall within 5 km Unprotected
 Plumbing: _____ Last Updated: _____
 Heating: _____ Last Updated: _____
 Electrical: _____ Last Updated: _____
 Roof: _____ Last Updated: _____
 Security: _____ Last Updated: _____

Current List of Loss Payees & Additional Insureds:

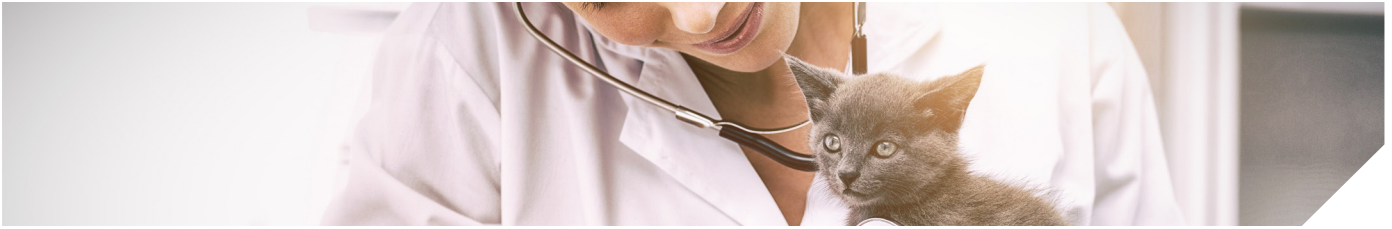
Please fully complete the following for Location One:

Values listed below should indicate the full CURRENT REPLACEMENT COST for all items including leased equipment.

Business Personal Property

Air Conditioning (check lease)	_____	Leasehold Improvements	_____
Alarm System (Monitored)	_____	Library	_____
Anesthetic Equipment	_____	Microscopes	_____
Autoclave	_____	Misc. Equipment – Medical	_____
Blood Chemistry Analyzer	_____	Misc. Equipment – Non Medical	_____
Blood Pressure Monitor	_____	Otoscopes	_____
Cages	_____	Phone Systems	_____
Centrifuge	_____	Photocopiers	_____
Circulating Water Blanket	_____	Refrigerators & Freezers	_____
Computers – Hardware/Software	_____	Scales	_____
Crematoriums	_____	Scavenging System	_____
Dental Equipment	_____	Stock – Drugs	_____
Electrocardiogram	_____	Stock – Food	_____
Electronic Equipment	_____	Surgery Equip – Instruments	_____
Endoscopes	_____	Surgery Equip – Lamps/Tables	_____
Fax Equipment	_____	Ultrasound	_____
Film Processing Unit	_____	Washing Machine	_____
Fluid Pumps	_____	X-Ray Machine & Equipment	_____
Furniture – Examination Room	_____	Other – please describe:	_____
Furniture – Office & Lobby	_____	Other – please describe:	_____
Incubator	_____	Other – please describe:	_____

TOTAL REPLACEMENT COST: _____



Mobile Property

Laptop Computers: \$ _____

Bowie Boxes: \$ _____

Mobile Vet Equipment (excluding laptops and bowie boxes): \$ _____

Authorization

Please sign and date below

Signature: _____

Name & Title: _____

Today's Date: _____

****The above form is intended to guide you in determining the full replacement cost of your property.
There may be additional items within your clinic that are not listed.****

