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PHARMACIST E&O NEW APPLICATION [CALGARY CO-OP]

Please note: This is an Annual Insurance program that has a common renewal date of **July 1**, each year. If you purchase a policy before or after **July 1**, there are no prorated premium calculations. The full annual program premium will be charged. No Refunds are permitted; the premium is fully retained.

Please indicate requested starting date _____

Your Name _____

Address _____

City _____ Province _____ Postal Code _____

Email Address _____ Phone Number _____

Employer _____

Is there a claim or suit pending, or has a claim been paid or judgement entered against the Applicant for damages on account of Malpractice, error or mistake, alleged or otherwise, occurring in the practice of his Profession? ☐ No ☐ **If yes, please attach details.**

Have you ever been disciplined by a licensing body? ☐ No ☐ **If yes, please attach details.**

Has insurance coverage ever been declined or cancelled? ☐ No ☐ **If yes, please attach details.**

Degree _____ Year of graduation _____

License # _____ # of years practicing in Canada: _____

Do you have Advanced Prescribing Authorization? Yes ☐ No ☐

Are you currently prescribing medication without a doctor's prescription in your practice (excluding minor ailments/generic substitution)? Yes ☐ No ☐

What type of pharmacist are you? _____
(Community, Clinical, Hospital, Home Care, Other)

This is an Occurrence Base policy. The following limits are available:

Per Occurrence	Aggregate	Premium	Please Indicate your choice
$5,000,000	$5,000,000	$355	☑

***** If you are actively prescribing medication in accordance with your license, an additional $100 premium applies**

COVERAGE CANNOT BE BOUND UNTIL PAYMENT IS RECEIVED. ANNUAL PREMIUM IS MINIMUM AND RETAINED.

Westland MyGroup
4-201 Brownlow Avenue Dartmouth, NS B3B 1W2
westlandmygroup.ca

T: 1-844-999-7687 ext. 2175
F: 1-866-966-0969
commercialprograms@westlandmygroup.ca

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Provide details of all Errors and Omissions or Professional Liability Insurance carried in the past three years:

Insurer	Period	Limit	Deductible

DECLARATION

The undersigned declares that all statements made in the Application and the information contained in documents submitted with it is true. It is agreed that the Application shall be the basis of the insurance contract. My signature below authorizes my broker and/or insurance company to collect, use and disclose any of this personal information, subject to the law and to my broker's or insurance company's policy regarding personal information, for the purposes of communicating with me, assessing my application for insurance and underwriting my policies, evaluating claims, detecting and preventing fraud, and analyzing business results. I specifically consent and agree with the provincial college, in which I am registered, providing information to confirm the statements which I have made under this application regarding my practice as a Licensed Clinical Pharmacist. I also understand that the premium is fully earned, and therefore, cancellation will not entitle me to a refund.

Signature _____ Dated _____

Payment options: **VISA** or **MASTERCARD** only

Total to be applied to credit card*:$ _____

*Plus applicable taxes where taxes apply. (Newfoundland -15%, Ontario - 8%, Manitoba - 7%, and Saskatchewan - 6%)

Credit card number _____

Expiry date: (mm/yy) _____

Name on card (please print): _____

Signature _____

Please email this application to commercialprograms@westlandmygroup.ca or fax to 1-866-966-0969
If you have any questions, please call us at 1-844-999-7687 ext. 2175. Your policy documents will follow shortly. Thanks for your business!

☐ I would like to receive additional insurance information that may benefit me and/or my business.

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