PHARMACY TECHNICIAN E&O NEW APPLICATION

Please note: The full annual program premium will be charged. No Refunds are permitted; the premium is fully retained. Coverage will start on the date specified or when we receive the completed application form and cannot be back dated.

Please indicate requested starting date _____ Province of Practice

Your Name _____

Address _____

City _____ Province _____ Postal Code _____

Employer _____ Phone Number _____

Email Address _____

In the past 3 years, has any claim been made or suit brought against you on account of any actual or alleged malpractice, error or mistake? ☐ 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: _____

What location type are your working at? _____
(Community, Clinical, Hospital, Home Care, Other)

	Per Occurrence	Aggregate	Premium	Please Indicate your choice
The following limits are available (Select one)	$2,000,000	$4,000,000	$125	☐
	$5,000,000	$5,000,000	$175	☐

It is recommended that all Hospital Employees choose $5,000,000 liability coverage

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

Insurer	Period	Limit	Deductible

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

Westland MyGroup
Unit 104- 100 Venture Run Dartmouth, NS, B3B 1L4
westlandmygroup.ca

T: 1-844-999-7687 ext. 5900
F: 1-866-966-0969
commercialprograms@westlandmygroup.ca

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When was the first time you obtained continuous insurance with no interruption/gap in coverage? Date _____

Please provide details as to any interruption/gap in coverage _____

What is your current active insurance policy?

Occurrence Based ☐ Claims Made ☐ No Active Policy ☐

DECLARATION

The Federal Government passed the Personal Information Protection and Electronic Documents Act (commonly referred to as PIPEDA) in order to ensure that an individual's personal information is not misused. At Westland MyGroup, we are aware of the importance of maintaining the privacy of our customers. Under various provincial College Regulations Acts, Insurance Coverage (h) & (I) the insurer will notify the College if the policy is cancelled, expires or ceases to meet the requirements of this regulation; and include a term to the effective that the policy continues in force in conformity with this regulation until the notice required by clause (h) is received by the College. We require your approval prior to sending this information to the various Colleges.

☐ Please check the box to approve.

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*:$ _____

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

Credit card number _____

Expiry date: (mm/yy) _____ CVV _____

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. 5900. 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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