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

Your Name _____

Employer _____

Personal Address _____

City _____ Province _____ Postal Code _____

Email Address _____ Phone Number _____

| | No | Yes |
|---|---|---|
| Are you a current licensed member in good standing with a provincial college of registered dietitians? | ☐ | ☐ |
| Has a claim ever been made against you in the past 5 years or are you aware of any facts, circumstances or allegations which may give rise to a claim against you? | ☐ | ☐ |
| Have you ever been investigated, summoned to a disciplinary panel, or been suspended from practice by any regulatory body governing the practice of your profession? | ☐ | ☐ |

**If you answered YES to the 2 claims questions, please contact Westland MyGroup before proceeding further.**

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

| Insurer | Period | Limit | Deductible |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**If No Prior coverage**, please indicate requested starting date _____

Do you work in a clinic? No ☐ Yes ☐     Do you work in a hospital? No ☐ Yes ☐

Are you self-employed? No ☐ Yes ☐ Other? _____

Are you authorized to perform restricted activities? No ☐ Yes ☐

**If yes, please list the activity or activities** _____

Do you travel to patients' or clients' homes? No ☐ Yes ☐

**If yes, please provide details** _____

**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

**This policy is a Claims Made Form. The following limits are available.**

| Per Occurrence | Aggregate | Premium |
|---|---|---|
| $5,000,000 | $5,000,000 | $225 + $25 Fee |

**Optional: (only available if E&O coverage is purchased)**          **Please Indicate your choice**

| | | | |
|---|---|---|---|
| Commercial General Liability | $2,000,000 | $105 | ☐ |

**\*\*\* CGL coverage only applies to Dieticians who work for a third party an/or those who may occupy space within a clinic. \*\*\***

| | | | |
|---|---|---|---|
| Cyber Liability Coverage | $50,000 | $80 | ☐ |

# 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 Registered Dietitian. 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\*:$   $270.00

\*Plus applicable taxes where taxes apply. (Ontario - 8%)

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.

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