Excel
SHEPPARD INSURANCE SERVICE AND RISK MANAGEMENT INC.
...an Assurex Global Partner

Unit 118, 14315 – 118 Avenue
Edmonton, Alberta T5L 4S6
Telephone No. (780) 421-1515 Fax No. (780) 425-0689
Toll Free (800) 663-2242 www.sheppardinsurance.com

PHARMACIST E&O APPLICATION – NEW ALBERTA

1. Your Name: _____

   Employer: _____

   Personal Address: _____, City_____, Province: ___, PC_____

   Email Address: _____ Phone Number _____

2. 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? ☐ Yes ☐ No If yes, please attach details.

3. This policy is an Occurrence Base. The following limits are available. Please indicate your choice.

Per occurrence	Aggregate	Premium	Please indicate your choice
$2,000,000	$2,000,000	$195	☐
$5,000,000	$5,000,000	$355	☐

Note: Coverage is not bound until payment is received. Annual premium is minimum and retained.

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

Insurer	Period	Limit	Deductible
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Payment Options: Cheque for amount indicated above attached to the application, Visa or MasterCard.

DECLARATION

The undersigned declares that all statements made in the Application and the information contained in documents attached is true. It is agreed that the Application shall be the basis of the 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 or insurance company's policy regarding personal information, for the purposes of communication 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 College of Pharmacists in my province of practice providing information to confirm the statements which I have made under this application regarding my practice as a clinical pharmacist.

_____ _____

Signature Date

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Name:

Payment Options: Cheque for amount indicated above attached to the application, Visa or MasterCard.

- ☐ Visa Credit Card Only
- ☐ MasterCard Credit Card Only

Card Number: _____

Amount of Payment: Circle One: $195.00 $355.00

Expiry Date: ___/_____ mm/yy

Signature: _____

Name on Card: _____

Please fax this form with the application to 780-425-0689.

Your policy documents will follow within 15 business days. Thanks for your business!